A GUIDE TO YOUR BENEFITS

HIGHMARK. Delaware

STATE OF DELAWARE
CONSUMER DIRECTED-HEALTH (CDH) GOLD PLAN
WITH

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) FUND

WELCOME!

This health care plan has been selected by the State Employee Benefits Committee of the State of Delaware. The plan benefits are funded by the State of Delaware and are administered by Highmark Blue Cross Blue Shield Delaware (Highmark Delaware).

Highmark Blue Cross Blue Shield Delaware's CDH Gold Plan offers many of the features of a Preferred Provider Organization (PPO) plan with the added advantage of a State-funded Health Reimbursement Account (HRA). The plan includes a $1,500 deductible for employee only (Employee) coverage and $3,000 for Family coverage. The HRA Fund pays the first $1,250 in deductible expenses for Employee-only and $2,500 for Family coverage. The member is financially responsible for the remaining in-network deductible ($250 for Employee only coverage and $500 for Family coverage). When the deductible is satisfied, in-network health care services are paid at 90%, with an in-network coinsurance maximum of $3,000 for Employee-only coverage and $6,000 for Family coverage.

There is a separate $1,500 out-of-network deductible for Employee-only coverage and $3,000 for Family coverage. When the deductible is satisfied, out-of-network health care services are paid at 70 percent, with an out-of-network coinsurance maximum of $6,000 for Employees and $12,000 for Families.

In addition, preventive care services are covered at 100 percent and are not subject to a deductible or coinsurance. This plan also includes coverage for services such as outpatient, inpatient, prenatal and postnatal care, emergency, mental health care, laboratory, x-ray, vision, chiropractic and many others.

For additional information contact Highmark Delaware's Customer Service staff at 1-800-633-2563.

This booklet may be viewed at: **http://ben.omb.delaware.gov/medical/bcbs/index.shtml.**

This booklet explains your benefits. Please read this booklet carefully and keep it handy.

Use the *Table of Contents* to find topics. A list of terms is given at the back of the booklet.

In this booklet, we sometimes abbreviate terms. For instance:

- **PPO** means Preferred Provider Organization
- **HRA** means Health Reimbursement Account. This refers to the HRA Fund.

This plan pays only "covered services." See the *Schedule of Benefits* for a list of covered services.

This booklet is not a contract. It explains your plan for easy reference. The benefits, terms and conditions of your plan are in an Account Contract on file with the Statewide Benefits Office, Office of Management and Budget. The Account Contract is the final determination of the benefits and rule of your plan.

This booklet explains the benefits in effect as of July 1, 2014. It replaces all previous booklets.

HINTS TO GET THE MOST FROM YOUR HEALTH CARE PLAN

- Always show your ID card when you need care.
- Always follow Highmark Delaware's Managed Care Requirements.
- Read this booklet.
- Information about claims, including Plan Activity Statements, which capture multiple processed medical claims and spending account transactions in one document, is available at **highmarkbcbsde.com**. The website includes information about how to set up your HRA account.
- Call us if you have any questions!

Remember! If you go to a network provider, your benefits are higher.

WHEN YOU HAVE QUESTIONS OR COMMENTS

Highmark Delaware welcomes questions, comments or suggestions. We study your comments to see how we can improve our service. Call or write Customer Service anytime you have a concern about Highmark Delaware's services, procedures or policies. We'll make every attempt to answer your questions and resolve any problems within 30 working days.

Here are reasons you may need to call us:

- asking about your plan;
- obtaining information about providers;
- reporting a lost or stolen ID card;
- ordering a new ID card;
- checking on the status of an approval from the Medical Management and Policy Department;
- asking about a claim; and
- getting language assistance.

So that we can learn about our network providers, you may also call or write us when you have a concern about:

- access to providers; and
- the care you received.

To Reach Us By Phone:

All Calls: 800.633.2563

Fax: 877.544.8726

To talk to a Customer Service Representative, call 8:00 AM to 8:00 PM Eastern Standard Time (EST), Monday through Friday.

You can also get the following information when you call outside the Customer Service Representative hours. Our automated system (VRU) is available Monday through Friday, 24 hours a day, and Saturday until midnight EST for:

- enrollment information;
- claims status; and
- ID card requests.

To Reach Us By Letter:

Write to:

Customer Service
Highmark Blue Cross Blue Shield Delaware
P. O. Box 1991
Wilmington, DE 19899-1991

To Reach Us In Person:

You may also visit us at several places in New Castle, Kent and Sussex Counties. To find out the days, times and locations, call Highmark Delaware's Customer Service Department at 800.633.2563.

To Reach Us On The Internet:

Internet Address: **highmarkbcbsde.com**

To Reach the Medical Management and Policy Department (for Managed Care):

Medical Management and Policy Department
Highmark Blue Cross Blue Shield Delaware
P. O. Box 1991
Wilmington, DE 19899-1991

All Calls: 800.572.2872

Medical Management representatives are available by telephone from 8:00 a.m. to 4:45 p.m. EST, Monday through Friday.

To Reach the Behavioral Health Care Department (for Mental Health and Substance Abuse Managed Care):

Behavioral Health Care Department
Highmark Blue Cross Blue Shield Delaware
P. O. Box 1991
Wilmington, DE 19899-1991

All Calls: 800.421.4577

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CDH GOLD SCHEDULE OF BENEFITS

The next pages describe what's covered under your CDH Gold Plan. Please read through these pages to make sure you know what's covered. Knowing what's covered helps you get the most from your health plan.

Many services have limits, deductibles or coinsurance. The limits indicated refer to a maximum benefit available for a service, not necessarily the number of days or visits determined to be medically necessary and appropriate to a particular condition.

Benefits are also subject to the exclusions listed in the section, "What is Not Covered." Benefits and exclusions are described in the next sections. Please read the next sections.

All payments are based on Highmark Delaware's allowable charge. Highmark Delaware determines the allowable charge.

Preexisting conditions are covered.

Any limits (such as days or dollar amounts) are combined for In-Network and Out-of-Network care. The combined limits determine when you reach the maximum.

DEDUCTIBLE/ COINSURANCE	**IN-NETWORK**	**OUT-OF-NETWORK**
Plan Year Deductible	$1,500 per person $3,000 per family	$1,500 per person $3,000 per family
Plan Year Coinsurance Expense Limit (excludes Deductible)	$3,000 per person $6,000 per family	$6,000 per person $12,000 per family

Note: Unless specified otherwise in the schedule below, a deductible applies. For an explanation how Plan Year Deductibles and Plan Year Coinsurance apply to your benefits, please see the section *Deductibles and Coinsurance*, below.

The HRA, funded each year by your employer, the State of Delaware, is $1,250 employee only or $2,500 for family and can be applied to in-network and/or out-of-network services. You can use HRA Fund dollars to pay eligible out-of-pocket health care costs. If you don't use the whole HRA Fund in one year, the unused amount will roll over to the next year, provided you continue to enroll in a CDH Gold Plan. However, if you terminate employment or leave the CDH Gold Plan, you can't take the HRA Fund with you.

SERVICE	**IN-NETWORK BENEFIT**	**OUT-OF-NETWORK BENEFIT**
Preventive Care		
■ Well Baby Care	100% Covered, no deductible	70% Covered, no deductible
■ Routine Physical Exams	100% Covered, no deductible	70% Covered, no deductible
■ Routine GYN Exams	100% Covered, no deductible	70% Covered, no deductible
■ Hemoglobin Tests	100% Covered, no deductible	70% Covered, no deductible
■ Cholesterol Tests	100% Covered, no deductible	70% Covered, no deductible
■ Blood Sugar Tests	100% Covered, no deductible	70% Covered, no deductible
■ Blood Antigen Tests	100% Covered, no deductible	70% Covered, no deductible
■ Lead Poison Screening Tests	100% Covered, no deductible	70% Covered, no deductible
■ Lab Charges for Pap Smear	100% Covered, no deductible	70% Covered, no deductible
■ Blood Occult	100% Covered, no deductible	70% Covered, no deductible

SERVICE	IN-NETWORK BENEFIT	OUT-OF-NETWORK BENEFIT
■ Routine Sigmoidoscopy	100% Covered, no deductible	70% Covered, no deductible
■ Colonoscopy	100% Covered, no deductible	70% Covered, no deductible
■ Barium Enema	100% Covered, no deductible	70% Covered, no deductible
■ Routine Mammogram	100% Covered, no deductible	70% Covered, no deductible
■ Routine Immunizations	100% Covered, no deductible	70% Covered, no deductible
■ Vision Exams	Not Covered	Not Covered
■ Hearing Exams	100% Covered, no deductible	70% Covered, no deductible
Hospital and Other Facility Benefits		
■ Inpatient Hospital Care	90% Covered for unlimited days	70% Covered for unlimited days
■ Surgical Facility Care	90% Covered	70% Covered
■ Skilled Nursing Facilities	90% Covered	70% Covered
	120 day limit, benefits renew after 180 days without care.	
Surgical and Medical Benefits		
■ Surgical Care	90% Covered	70% Covered
■ Anesthesia	90% Covered	70% Covered (covered in-network at network facilities)
■ Inpatient Medical/Consultant Care	90% Covered	70% Covered
■ Organ Transplants	See Benefit Description	See Benefit Description
■ Infertility Services (limited to $10,000 per member's lifetime)	75% Covered	55% Covered
Maternity Benefits		
■ Prenatal and Postnatal Care	90% Covered	70% Covered
■ Inpatient Hospital Care	90% Covered	70% Covered
■ Birthing Center	90% Covered	70% Covered
■ Obstetric Care	90% Covered	70% Covered
Emergency Services		
■ Emergency Ambulance and Paramedic Services	90% Covered	70% Covered
■ Emergency Facility – Acute Hospital	90% Covered	90% Covered (subject to in-network deductible)
■ Freestanding Emergency Facility	90% Covered	90% Covered (subject to in-network deductible)
■ Urgent Care Center	90% Covered	70% Covered
■ Medical Emergency Care (doctor's care in an emergency facility)	90% Covered	90% Covered (subject to in-network deductible)

SERVICE	IN-NETWORK BENEFIT	OUT-OF-NETWORK BENEFIT
Diagnostic and Therapeutic Services		
Outpatient Care		
■ Chemotherapy, Radiation and Inhalation Therapy, Dialysis	90% Covered	70% Covered
■ Physical Therapy	90% Covered	70% Covered
■ Occupational Therapy	90% Covered	70% Covered
■ Speech Therapy	90% Covered	70% Covered
	Physical, Occupational and Speech Therepies: The maximum number of visits allowed for a specific diagnosis is determined by medical necessity.	
■ Cognitive Therapy	90% Covered	70% Covered
■ Cardiac Therapy	90% Covered	70% Covered
	Limited to 3 sessions per week and 12 weeks of treatment. Care beyond this limit requires medical review and approval.	
■ Applied Behavior Analysis (limited to $36,000 per plan year for the treatment of autism spectrum disorders for members under age 21)	90% Covered	70% Covered
■ Lab Tests	90% Covered	70% Covered
■ Imaging Services (includes High-Tech Imaging Services)	90% Covered	70% Covered
■ Machine Tests	90% Covered	70% Covered
Inpatient Care		
■ Therapeutic Services	90% Covered	70% Covered
■ Diagnostic Services	90% Covered	70% Covered
Other Covered Services		
■ Hospice	90% Covered	70% Covered
		Limited to 365 days.
■ Home Health Care	90% Covered	70% Covered
		Limited to 240 visits per plan year.
■ Home Infusion	90% Covered	70% Covered
■ Inpatient Private Duty Nursing	90% Covered	70% Covered
		Limited to 240 hours in a 12-month period.
■ Doctor's Visits	90% Covered	70% Covered
■ Specialist/Referral Care Care (including eye care for medical treatment and management of eye conditions or diseases)	90% Covered	70% Covered
■ Diabetic Education	90% Covered	70% Covered
■ Nutritional Counseling	90% Covered	70% Covered
■ Allergy Tests & Treatment	90% Covered	70% Covered
■ Chiropractic Care	90% Covered	75% Covered
		Limited to 30 visits per plan year.

SERVICE	IN-NETWORK BENEFIT	OUT-OF-NETWORK BENEFIT
■ Durable Medical Equipment	90% Covered	70% Covered
	Limited to one hearing aid per ear every 3 years for children less than 24 years of age.	
■ Care for Morbid Obesity	See Benefit Description	See Benefit Description
▪ Office Visits and Labs	See Benefit Description	See Benefit Description
▪ Bariatric Surgery	Blue Distinction Center for Bariatric Surgery (BDCBS): 90% Covered Non-BDCBS, but in-network: 75% covered. (see next page)	55% Covered.
▪ Bariatric Surgery	The 75% coverage level applies for the duration of an inpatient admission, or for all services on the day of an outpatient procedure, and includes: ■ inpatient facility accommodation and ancillary charges ■ outpatient facility and ancillary charges ■ all professional services ■ all diagnostic & therapeutic services.	
Mental Health Care and Substance Abuse Treatment		
■ Inpatient and Partial Hospital/Intensive Outpatient Care	90% Covered for unlimited days	70% Covered for unlimited days
■ Outpatient Care (Office Visits)	90% Covered	70% Covered

HIGHLIGHTS OF THE HEALTH REIMBURSEMENT ARRANGEMENT (HRA) FUND

When you enroll in the CDH Gold Plan, you will also have access to a State-funded Health Reimbursement Arrangement (HRA), also referred to as a Health Reimbursement Account (HRA) Fund to offset a large part of the deductible. The State of Delaware provides the funds in your HRA Fund on a tax-free basis and at no cost to you. The amount allocated to your HRA Fund is based on your level of coverage. For the 2014-2015 plan year, if you enroll in employee coverage, the State will provide $1,250 in your HRA Fund; if you enroll for employee and spouse, employee and child/ren, or family coverage, the State will provide $2,500 in your HRA Fund.

When you have an eligible healthcare claim expense, the allowable claim expense will be automatically deducted from your HRA fund first. Then you are responsible for paying the rest of the deductible before the plan begins to pay a portion of your expenses. For the plan year, you are responsible for deductible amounts of only $250 for employee only coverage or $500 for family coverage, after the HRA Fund is exhausted. Then, the plan begins to pay 90% for eligible expenses.

If you do not use all the money allocated for your HRA Fund, the balance rolls over from year to year, provided you continue to enroll in a CDH Gold Plan. Claims for reimbursement from the HRA Fund must be made within 90 days after the end of the plan year in which the claim was incurred.

The HRA Fund has an enhanced 90-day 'run-out' period immediately following the end of each plan year (June 30). During this time, any current year claims can be paid with prior year funds during the run out period if the previous plan year's HRA Fund has been exhausted. Funds for the new plan year cannot be used to pay the previous plan year expenses. At the conclusion of the run out period, funds from the previous plan year would rollover to the new plan year providing the member remained in the CDH Gold Plan.

If you enroll in the CDH Gold Plan or change coverage in the CDH Gold Plan at a time other than the beginning of the plan year, the HRA Fund available will be pro-rated, and the following will apply to determine your applicable HRA Fund amount for the remainder of the plan year. In any plan year, if you:

- Enroll or change tier by 9/1: you'll receive the full amount of $1250 for employee/$2500 for family
- Enroll or change tier after 9/1 but before 1/1: you'll receive $937.50 for employee/$1875 for family
- Enroll or change tier after 1/1 but before 4/1: you'll receive $625 for employee/$1250 for family
- Enroll or change tier after 4/1 but before 7/1: you'll receive $312.5 for employee/$625 for family

Please note that while the HRA Fund is prorated depending on your enrollment date, the health plan deductibles and coinsurance expense limits are not.

Scenarios describing other changes in HRA Fund levels due to changes in coverage are presented below.

Scenario #1

Change in enrollment from employee coverage to family (which includes employee + spouse, or employee + child coverage)

To Pro-rate the Increase in HRA Funding:

1. Calculate the difference between family and individual funding at start of plan.
2. Multiply the difference by % based on time of change: 100% (7/1-9/30), 75% (10/1-12/31), 50% (1/1-3/31), 25% (4/1-6/30).

3. Add this amount to member's original funding.
4. Total funding will be reduced by HRA Funds already exhausted by the individual.

HRA Funding Increase

	1st Qtr Change	2nd Qtr Change	3rd Qtr Change	4th Qtr Change
1st Quarter Enrollment - Subscriber only (7/1/14-9/30/14)	$2,500.00	$2,187.50	$1,875.00	$1,562.50
2nd Quarter Enrollment - Subscriber only (10/1/14-12/31/14)		$1,640.63	$1,406.25	$1,171.88
3rd Quarter Enrollment - Subscriber only (1/1/15-3/31/15)			$937.50	$781.25
4th Quarter Enrollment - Subscriber only (4/1/15-6/30/15)				$390.63

Example #1: Employee enrolled 7/1/2014 and adds spouse 11/1/2014

1. $1,250.00 is the difference in funding
2. $937.50 is 75% of the difference
3. $2,187.50 is original funding plus #2
4. Funding will increase to $2,187.50 less any amount already used.

Scenario #2

Change in enrollment from family (which includes employee + spouse, or employee + child coverage) to employee coverage

To Pro-rate the Decrease in HRA Funding:

1. Calculate the difference between family and employee funding at start of plan.
2. Multiply the difference by % based on time of change: 100% (7/1-9/30), 75% (10/1-12/31), 50% (1/1-3/31), 25% (4/1-6/30).
3. Subtract this amount from member's original funding.
5. Total funding will be reduced by HRA Funds already exhausted by the family.

HRA Funding Decrease

	1st Qtr Change	2nd Qtr Change	3rd Qtr Change	4th Qtr Change
1st Quarter Enrollment - Subscriber only (7/1/14-9/30/14)	$1250.00	$1,562.50	$1,875.00	$2,187.50
2nd Quarter Enrollment - Subscriber only (10/1/14-12/31/14)		$1,171.88	$1,406.25	$1,640.62
3rd Quarter Enrollment - Subscriber only (1/1/15-3/31/15)			$937.50	$1,093.75

4th Quarter Enrollment - Subscriber only (4/1/15-6/30/15)	$546.87

Example #2: Employee + Spouse enrolled 10/1/2014 removes spouse from policy 2/1/2015.

1. $937.50 is the difference in funding
2. $468.75 is 50% of the difference
3. $1406.25 is the original funding minus #2
4. Funding will decrease to $1406.25 less any amount already used.

DEDUCTIBLES AND COINSURANCE

In the *Schedule of Benefits*, we refer to deductibles and coinsurance; there are no copays with the CDH Gold Plan. These amounts are your share of payment. These terms are described below.

IN-NETWORK DEDUCTIBLE AND COINSURANCE EXPENSE LIMITS

Your In-Network benefits have a $1,500 plan year deductible per person. You pay the first $1,500 for services.

You also have a $3,000 plan year family deductible. Deductible payments for all family members combine to meet the family deductible. Then, no more deductible is taken for any family member for the rest of the year.

After the deductible is met, most In-Network benefits are paid at 90% of the allowable charge. The 10% difference is the coinsurance. This is the amount you pay.

Your In-Network benefits have a $3,000 plan year coinsurance expense limit per person. This applies when the coinsurance adds up to $3,000. Then, we pay 100% for the rest of the year. The 100% is based on the allowable charge.

You have a $6,000 plan year family coinsurance expense limit. Coinsurance payments for all family members combine to meet the family coinsurance expense limit. Then, we pay 100% for all members for the rest of the year. The 100% is based on the allowable charge.

OUT-OF-NETWORK DEDUCTIBLE AND COINSURANCE EXPENSE LIMITS

Your Out-of-Network benefits have a $1,500 plan year deductible per person. You must pay the first $1,500 of allowable charges for services.

You also have a $3,000 plan year family deductible. Deductible payments for all family members combine to meet the family deductible; however, no single family member will have more than a $1,500 deductible applied. Once the family deductible is satisfied, no more deductible is taken for any family member for the rest of the year.

After the deductible is met, most Out-of-Network benefits are paid at 70% of the Highmark Delaware allowable charge. This means the difference of 30% is your coinsurance payment.

Your Out-of-Network benefits have a $6,000 plan year coinsurance expense limit per person. This applies when the coinsurance adds up to $6,000. Then, we pay 100% for the rest of the year. The 100% is based on the Highmark Delaware allowable charge.

You have a $12,000 plan year family coinsurance expense limit. Payments for all family members combine to meet the family coinsurance expense limit. Then, we pay 100% for all members for the rest of the year. The 100% is based on the Highmark Delaware allowable charge.

Amounts billed by non-participating providers that exceed Highmark Delaware's allowable charge are not applied to any deductible or coinsurance expense limit.

HOW THE DEDUCTIBLE AND COINSURANCE WORK

Example #1:

Suppose you have employee only coverage and incur In-Network medical expenses of $50.00 in allowable charges. Here's how your In-Network deductible would be reduced:

Your In-Network deductible is	$1,500
Employer funding provided through your HRA	$1,250
Less: Your medical expenses	$50
Your HRA pays your provider	$50
Equals: The amount you still have to pay to meet your In-Network deductible	$1,450
The amount remaining in your HRA is	$1,200

Example #2:

Suppose you have Family coverage and one family member incurs In-Network medical expenses of $25,000 in allowable charges for surgery. Here's how your In-Network benefits will work:

Allowable Charges for surgery	$25,000
Your In-Network deductible is	$1,500
Employer funding provided through your HRA pays	($1,500)
Deductible you pay	$0
HRA balance	$1,000
Remaining medical expenses	$23,500
Less: CDH Gold Plan (90%) payment	($21,150)
Balance (10% member coinsurance)	$2,350

You may use the $1,000 HRA balance to pay a portion of the member coinsurance.

Member coinsurance	$2,350
Less: HRA balance	($1,000)
The remaining amount of coinsurance you must pay	$1,350

Example #3:

When you meet your deductible and exhaust your HRA funds, your In-Network benefits are paid at 90% of allowable charges. This means your coinsurance is 10% (100% - 90% = 10%). Suppose you've met your deductible, and incur In-Network medical expenses of $500 in allowable charges. Here's how your In-Network coinsurance expense limit is reduced:

Your In-Network coinsurance expense limit is	$3,000
Less: Your coinsurance times the medical expenses (10% X $500)	$50
Equals: The amount of coinsurance you still have to pay to meet your In-Network coinsurance expense limit:	$2,950

When you meet your In-Network coinsurance expense limit, In-Network benefits are paid at 100% of allowable charges for the rest of the plan year.

COMBINING IN-NETWORK AND OUT-OF-NETWORK COINSURANCE

When adding up your deductible and coinsurance, combine the amounts from In-Network and Out-of-Network benefits.

For example:

Amount of coinsurance from In-Network services:	$2,850
Amount of coinsurance from Out-of-Network services:	$750
Total combined amount:	$3,600

The total combined amount goes to your coinsurance expense limit. In this example, the In-Network limit was met. (The In-Network limit is $3,000, and the combined amount exceeds $3,000.) So, all future In-Network care through the year is paid at 100%.

The Out-of-Network limit hasn't yet been met. (The Out-of-Network limit is $6,000.) Out-of-Network care isn't paid at 100% until the combined amounts reach $6,000.

You may combine your In-Network and Out-of-Network deductibles in the same way.

WHAT'S NOT INCLUDED IN THE COINSURANCE EXPENSE LIMIT

The coinsurance expense limit does not include:

- deductible amounts;
- coinsurance you pay for artificial reproductive technologies;
- coinsurance you pay for bariatric surgery; and
- amounts billed by non-participating providers that exceed Highmark Delaware's allowable charge.

CARRYOVER AND PRO-RATION

There is no carryover into a subsequent plan year of any deductibles or coinsurance from a previous plan year.

HRA funds not used in a plan year are rolled over into your CDH Gold Plan for the following year provided you are continuously enrolled in the CDH Gold Plan.

There is no pro-ration of deductibles or coinsurance expense limits if you are enrolled in the plan for part of the year.

The pro-ration of the HRA Fund is explained in the section, *Highlights of the Health Reimbursement Arrangement (HRA) Fund*, above.

HOW TO USE YOUR CDH GOLD BENEFITS

In this section, we describe how the CDH Gold Plan works. Please read these rules carefully. Call us if you have any questions.

TWO LEVELS OF BENEFITS

With the CDH Gold Plan, you can receive two levels of benefits:

- With In-Network benefits, your care is covered at the highest level.
- With Out-of-Network benefits, coverage is reduced. The amount you pay is greater.

HOW TO RECEIVE IN-NETWORK BENEFITS

To receive In-Network benefits, see a network provider when you need care. The network providers are listed in the Provider Network Directory or online at **highmarkbcbsde.com. If you receive care without using a network provider, your benefits are reduced. This means, your share of payment is greater!**

You must also follow Highmark Delaware's Managed Care Requirements to avoid penalties.

Some network providers are not approved by us to give all health services at the In-Network level. For example, a network hospital may not be approved as a network provider for outpatient lab tests. You should always check the Provider Network Directory before you have care.

HOW TO RECEIVE OUT-OF-NETWORK BENEFITS

With Out-of-Network benefits, you may see any provider you choose. There are higher deductibles and coinsurance. This means your share of payment is greater. **You must also follow Highmark Delaware's Managed Care Requirements to avoid penalties.**

If you choose to see an out-of network provider, there are ways to save money. Many doctors and other providers contract with Highmark Delaware. These providers agree to accept Highmark Delaware's allowable charge as full payment. They are called "participating providers." They cannot bill you more than our allowable charge, even if their normal charge is higher. And, these providers file claims with Highmark Delaware for you. So, you don't need to complete claim forms.

Non-participating providers don't have contracts with Highmark Delaware. They may bill for amounts over our allowable charge. **Be sure to ask if your provider participates with Highmark Delaware.**

EXCEPTIONS TO THE CDH GOLD RULES

Here are some instances when you don't have to use a network provider. You'll still get benefits at the In-Network level. Please be careful when you read the following. It's important that you understand the exceptions. Call Customer Service at 1.800.633.2563, if you have questions.

EMERGENCY CARE

If you need emergency care, go to the nearest emergency provider. Benefits will be paid at the same level both In-Network and Out-of-Network, at Highmark Delaware's allowable charge. See the *Emergency and Urgent Care* section for more information.

OUTPATIENT LAB AND IMAGING TESTS

Usually you'll need to go to a network lab or imaging provider. However, sometimes a network provider will give you a lab or imaging test in the course of other treatment. For example:

- Lab and imaging tests done during outpatient surgery are paid at the in-network level if the surgical facility is a network provider.
- X-rays done for oral surgery are paid at the in-network level if the surgeon is a network provider. See Surgical Benefits to see when oral surgery is covered.
- Lab and imaging tests done as part of hospice or home health care are paid at the in-network level. These tests must be billed by the provider.
- Imaging done and billed by a network orthopedic doctor is paid at the in-network level.

Use of Provider for Laboratory Services

Highmark Delaware members, hospitals, and physicians must use the designated network provider of laboratory services for claims to process at the in-network level. As is the case for any service, members may be responsible for the difference between the billed amount and the amount paid by Highmark Delaware when an out-of-network provider is utilized. If a member lives and receives services outside of Highmark Delaware's service area, the local Blue Plan's provider network contract will apply.

OUT OF AREA SERVICES

You can use other Blue Cross Blue Shield provider networks when you have care outside Highmark Delaware's provider area. If you use an Out-of-Area network provider, your benefits will be paid In-Network. When you need out-of-area care, call 800.810.BLUE (800.810.2583) to find out which providers are in the network.

THE BLUECARD® PROGRAM

Follow these five easy steps for health coverage when you're away from home in the United States:

1) Always carry your current Highmark Delaware ID card.
2) In an emergency, go directly to the nearest hospital
3) To find names and addresses of nearby doctors and hospitals, visit the BlueCard Doctor and Hospital Finder or call BlueCard *Access*® at 800.810.BLUE (800.810.2583).
4) Call Highmark Delaware for pre-certification or prior authorization, if necessary (refer to the phone number on your Blue Plan ID card).
5) When you arrive at the participating doctor's office or hospital, simply present your Highmark Delaware ID card.

After you receive care:

- You should not have to complete any claim forms.
- You should not have to pay up front for medical services, other than the usual out-of-pocket expenses (non-covered services, deductible, copayment and coinsurance)
- If your claim is subject to out-of-pocket expenses, Highmark Delaware will send you an EOB showing these amounts. If there are no out-of-pocket expenses, the EOB will be available at **highmarkbcbsde.com**.

MANAGED CARE REQUIREMENTS

The benefits provided under this plan are subject to Highmark Delaware's managed care requirements. These requirements are described below, and are administered by Highmark Delaware's Medical Management and Policy Department (MMP).

MEDICAL MANAGEMENT SERVICES

Determining Care Coverage

For benefits to be paid under your CDH Gold Plan, services and supplies must be considered "Medically Necessary and Appropriate."

Highmark Delaware's MMP, or its designated agent, is responsible for ensuring that quality care is delivered to members within the proper setting, at the appropriate cost and with the right outcome.

MMP or its designated agent will review your care to assure it is "medically necessary and appropriate." Such care:

- is consistent with the symptom or treatment of the condition;
- meets the standard of accepted professional practice;
- is not primarily for anyone's convenience;
- is the most appropriate supply or level of care safely provided, and
- is not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

A Summary of Highmark Delaware's Care/Utilization Process

To help ensure that care is provided in the appropriate setting, MMP administers a care utilization review process comprised of prospective, concurrent and retrospective reviews. In addition, MMP conducts discharge planning. These activities are conducted via telephone or on-site by an MMP nurse working with a physician advisor who is in direct contact with the member's physician.

Here is a brief description of these review procedures:

Prospective Review:

Prospective review, also known as precertification or pre-admission review, begins once a request for inpatient services is received. Requests can be for inpatient hospital care (for medical, mental health and substance abuse diagnoses) and for skilled nursing facility care.

After receiving the request for inpatient hospital or skilled nursing services, the MMP nurse:

- Gathers information needed to make a decision, including patient demographics, diagnosis, and plan of treatment;
- Confirms care is "Medically Necessary and Appropriate";
- Authorizes care or refers to a physician advisor for a determination;
- When required, assigns an appropriate length of hospital stay.

Emergency and Maternity Admissions

For emergency admissions, you must call us within 48 hours of admission. If you can't call yourself, your provider, a family member or a friend may call us. Highmark Delaware will review the admission. If approved, we'll assign an initial length of stay.

Maternity admissions don't require Highmark Delaware's prior authorization. However, extended hospital stays must be authorized.

Concurrent Review

Concurrent review occurs during the course of inpatient hospitalization and is used to ensure appropriateness of admission, length of stay and level of care at an inpatient facility.

The MMP Nurse:

- Contacts the facility's utilization reviewer;
- Checks the member's progress and ongoing treatment plan;
- Decides, when necessary, to either extend the member's care, offer an alternative level of care, or refer to the physician advisor for further determination of care.

Discharge Planning

Discharge planning is a review of the case to identify the member's discharge needs. The process begins prior to admission and extends throughout the member's stay in a facility. Discharge planning ensures continuous, quality care and is coordinated with input from the member's physician.

To plan effectively, the MMP nurse assesses the member's:

- Level of function pre- and post-admission;
- Ability to perform self-care;
- Primary caregiver and support system;
- Living arrangements pre- and post-admission;
- Special equipment, medication and dietary needs;
- Obstacles to care;
- Need for referral to case management or disease management
- Availability of benefits or need for benefit adjustment.

Retrospective Review

Retrospective review occurs when a service or procedure has been rendered prior to MMP notification.

Case Management Services

When a member is injured, seriously ill or considering certain types of surgery, Case Management may begin a collaborative process that involves MMP and case managers, the member, their family or significant others, physicians and institutional providers. Using communication, education and available resources, Case Management assesses plans, implements, coordinates, monitors and evaluates all of the options and services required to meet the member's health needs, always with the goal of enabling the member to reach optimum recovery in a timely manner.

Preauthorization for Other Services

In addition to inpatient care, certain other services require preauthorization by Highmark Delaware. These include:

- Certain outpatient hospital surgical procedures, including hysterectomy and laminectomy (lower back surgery)
- bariatric surgery

- advanced radiology (Some examples include: CAT and PET scans, MRIs, and MRAs)
- assisted reproductive technologies, and
- certain home health services.

The member's primary physician and any other network specialist is responsible for obtaining preauthorization for any service that requires it.

AUTHORIZATION FOR URGENT CARE SERVICES

You do not need to obtain prior authorization (for those services that require it) from Highmark Delaware, for services that your physician considers to be urgent, if these services are obtained outside of Highmark Delaware's normal business hours (8:00 AM to 4:45 PM), over the weekend or during holidays. See the definition of Urgent Care in the *Emergency and Urgent Care* section, below. You must contact Highmark Delaware for post-service authorization for these services within two business days following your care.

Care in an urgent care center/medical aid unit does not require prior authorization.

USE OF PARTICIPATING PROVIDERS

All providers who participate with Highmark Delaware have agreed to follow Highmark Delaware's managed care requirements. In circumstances where an authorization for a service is required, the participating provider cannot bill you unless:

- Highmark Delaware's authorization requirements were followed,
- the service was not authorized, and
- having been informed of Highmark Delaware's decision, you chose to have the service anyway, and agreed in writing to be responsible for payment.

Non-participating providers and providers outside the Highmark Delaware service area may not know about the requirements. It's up to you to call Highmark Delaware if you have care that requires authorization. If the requirements aren't followed, you may be billed 100% of the charges.

GENERAL CONDITIONS

- Highmark Delaware does not pay for services that are not covered, even when the Medical Management and Policy or Behavioral Health Department authorizes, for example, an inpatient admission, except for optional benefits authorized by Highmark Delaware through individual case management.
- If you do not comply with the managed care requirements, Highmark Delaware will reduce or deny payment. However, upon appeal Highmark Delaware reserves the right to approve payment for care that was not authorized in advance but is subsequently determined to have been medically necessary.
- Any payments you must make because you or your provider fail to follow the managed care requirements are not credited toward any deductible or coinsurance requirement.
- You don't need to follow Highmark Delaware's managed care requirements if this plan is secondary. See the section, *Coordination of Benefits*, for more information.

APPEALS

You may disagree with a decision either the Medical Management and Policy or Behavioral Health Department makes. If you disagree, you may file a written appeal with us. See the section, A Guide To Filing Claims and Appeals, for more information.

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PREVENTIVE SERVICES

Check the *Schedule of Benefits* for benefit levels and any limits that may apply.
Follow managed care requirements to get the highest benefit!

PREVENTIVE SERVICES

Highmark Delaware promotes preventive care to help you stay well, and these services are provided at no cost to you when you use a network provider. We administer these benefits according to Highmark Delaware's Preventive Health Guidelines materials. These materials contain details of when we pay for preventive care, and they are available online at **highmarkbcbsde.com**. All the terms and conditions of your benefit plan apply to the Preventive Health Guidelines materials.

In-network preventive care is provided at 100% of the allowable charge, and is not subject to the deductible.

Please note: Highmark Delaware has the right to change these benefits at any time. Claims for care provided for preventive services submitted with a medical or family history diagnosis are paid at the diagnostic benefit level.

EXAMINATIONS

Benefits are provided for:

- well baby care;
- routine physical exams; and
- routine GYN exams and Pap smears.

TESTS AND SCREENINGS

Some examples of covered routine tests, screenings and counseling are:

- blood antigen test for prostate cancer;
- blood occult;
- blood sugar test;
- cholesterol test;
- colonoscopy;
- flexible sigmoidoscopy;
- hemoglobin test;
- lead screening;
- mammogram;
- osteoporosis screening;
- alcohol misuse, and tobacco use and tobacco-caused disease counseling;
- depression screening for adolescents and adults; and
- tuberculin testing.

ROUTINE IMMUNIZATIONS

Some examples of covered routine immunizations are:

- DTaP and combinations (diphtheria, pertussis, tetanus);
- Hepatitis A;
- Hepatitis B;

- Hib (haemophilus influenza);
- Influenza;
- IPV (polio);
- Meningitis;
- MMR (measles, mumps, rubella);
- Pneumococcal;
- Td (Tetanus); and
- Varicella (chickenpox) vaccine;

Immunizations considered by Highmark Delaware to be experimental are not covered.

PREVENTIVE COVERAGE FOR WOMEN

Certain benefits will be covered with no cost sharing to the member, including:

- contraceptives covered under the medical/surgical benefit, including:
  - injections, such as Depo-Provera.
  - implantable intra-tubal occlusion devices, IUDs, cervical caps and diaphragms
  - over-the-counter contraceptives including female condoms, sponges and spermicides
- sterilization procedures, such as tubal ligation, by a physician.
- well women visits: two preventive visits and two OB/GYN visits per year.
- HPV Test: covered once every 3 years for women age 30 and older, or annually if Pap test yields other than normal results.
- screening for gestational diabetes in pregnant women between 24 and 28 weeks of gestation, and at the first prenatal visit for pregnant women at high risk for diabetes.
- two counseling session per plan year for sexually transmitted infections (STIs) including the human immunodeficiency virus (HIV)
- breastfeeding Supplies: Breastfeeding equipment in conjunction with each birth. Breastfeeding equipment includes breast pumps and supplies.

For more information about these and other preventive services, please refer to Highmark Delaware's Preventive Health Guidelines at highmarkbcbsde.com.

ROUTINE HEARING EXAMS

Hearing exams are covered as part of a routine physical exam. Visits to a specialist or audiologist are covered under *Specialist Care*.

HOSPITAL AND OTHER FACILITY BENEFITS

Check the *Schedule of Benefits* for benefit levels and any limits that may apply.
Follow managed care requirements to get the highest benefit!

INPATIENT HOSPITAL CARE

Your care is covered for the following services when you're in the hospital. Please check the *Schedule of Benefits* for any day limits.

Room And Board

Room and board, special diets and general nursing care are covered. Payment is made at the semiprivate room rate. If you have a private room, you pay the extra charge above the semiprivate rate. We cover private rooms only when medically necessary. We also cover intensive care when medically necessary.

Other Hospital Care

When medically necessary, we cover:

- use of operating room and recovery room;
- drugs listed in the U.S. Pharmacopoeia or National Formulary;
- therapy:
  - chemotherapy by a doctor;
  - infusion therapy;
  - occupational therapy as called for in your doctor's treatment plan when:
    - needed to help your condition improve in a reasonable and predictable time; or
    - needed to establish an effective home exercise program.
  - physical therapy as called for in your doctor's treatment plan when:
    - done by a doctor or licensed physical therapist; and
    - needed to help your condition improve in a reasonable and predictable time; or
    - needed to establish an effective home exercise program.
  - radiation therapy for cancer and neoplastic diseases;
  - inhalation therapy by a doctor or registered inhalation therapist;
  - speech therapy, when:
    - done by a licensed or state certified speech therapist; and
    - ordered by a doctor; and
    - done to improve speech impairment caused by:
      - disease;
      - trauma;
      - congenital defect, or
      - recent surgery.
  - cognitive therapy done by an approved provider. The diagnoses eligible for coverage are:
    - stroke with cognitive impairment; or
    - head injury or trauma.
  - cardiac therapy. Services done on an inpatient and outpatient basis are combined to determine when the limit is met. Services must begin within 4 months following certain serious conditions or procedures.
- surgical dressings;
- administration of blood or blood plasma (but not blood itself);
- machine tests;
- imaging exams (such as X-rays);

- durable medical equipment;
- lab tests; and
- dialysis.

MATERNITY CARE

Hospital and Birthing Center care is covered for:

- pregnancy;
- childbirth; and
- miscarriage.

Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)

This plan conforms with this federal law, which states that group health plans may not restrict mothers' and newborns' benefits for a hospital length of stay related to childbirth to less than:

- 48 hours following a vaginal delivery, and
- 96 hours following a cesarean section.

Maternity lengths of stay may be less than the 48 or 96 hours *only* if both the patient and physician agree.

NEWBORN CARE

Hospital care for a newborn child is covered, provided the child is enrolled.

See the section entitled "A Guide to Enrollment", *Changes in Enrollment (Newborns)* for more information.

OUTPATIENT SURGICAL FACILITY

You're covered for minor surgeries done as an outpatient. Surgeries may be done at:

- hospitals; or
- approved ambulatory surgical centers.

Dental surgery is normally only covered when done in a dentist's or an oral surgeon's office. Dental surgery done in a hospital outpatient department or ambulatory surgical center must be approved by Highmark Delaware. Please refer to the Dental Surgery description in the section entitled *Surgical and Medical Benefits*, below.

EMERGENCY ROOM

You're covered for emergency care in emergency facilities. See the *Emergency and Urgent Care* section for more information.

SKILLED NURSING FACILITY

You're covered for confinement in a skilled nursing facility. Highmark Delaware must approve your stay. We may review your stay every 14 days. A confinement includes all admissions not separated by 180 days. Benefits renew after 180 days without inpatient skilled nursing facility care.

The plan covers:

- skilled nursing and related care as an inpatient; and
- rehabilitation when needed due to illness, disability or injury.

The plan doesn't cover intermediate care, rest and homelike care, or custodial care.

SURGICAL AND MEDICAL BENEFITS

Check the *Schedule of Benefits* for benefit levels and any limits that may apply.
Follow managed care requirements to get the highest benefit!

SURGICAL BENEFITS

Surgical services include:

- cutting and operative procedures;
- treatment of fractures and dislocations; and
- delivery of newborns.

These services can be done:

- in hospitals;
- in approved ambulatory surgical centers;
- at home; and
- in the doctor's office.

The allowable charge includes pre- and post- operative care done by surgeons. We don't pay separate charges for such care.

Dental Surgery

Dental surgery is only covered for:

- extracting bony impacted teeth; and
- correcting accidental injuries (to the jaws, cheeks, lips, tongue, roof and floor of mouth).

Such surgery is covered when done in a dentist's or an oral surgeon's office. Dental surgery done in a hospital outpatient department or ambulatory surgical center must be approved by us.

Coverage is not provided for the extraction of normal, abscessed or diseased teeth or for the removal, repair or replacement of teeth damaged due to accidental injuries or disease, even if such services are necessary to correct other injuries suffered as a result of accident or disease.

When it is medical necessary, due to a member's physical, intellectual or other medically compromised condition, for dental services to be performed under general anesthesia outside of a dentist's or oral surgeon's office, Highmark Delaware will cover the anesthesia and facility charges. Highmark Delaware must approve such care at least two business days prior to services being performed.

Multiple Surgical Procedures

When one doctor does more than one procedure on a patient in a single day:

- we provide full contract benefits for the procedure with the highest allowable charge; and
- we determine coverage for the other procedures using special rules on multiple surgical procedures.

When a procedure normally done in one stage is done in two or more stages:

- we cover the entire procedure as one stage.

Women's Health and Cancer Rights Act of 1998

This federal law requires coverage of mastectomy-related services, provided in a manner determined in consultation with the attending physician and patient. This coverage includes:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymph edemas.

ANESTHESIA

Anesthesiologist services are covered when medically necessary.

ORGAN TRANSPLANTS

This section describes the coverage for the following human organ transplants:

- heart;
- lung/lobar lung;
- combined heart and lung;
- pancreas;
- combined pancreas and kidney;
- small bowel;
- liver;
- combined small bowel and liver;
- multivisceral;
- autologous bone marrow/stem cell;
- allogenic bone marrow/stem cell; and
- kidney.

The level of coverage for these transplants depends upon the facility where the transplant is performed:

- Transplants performed at a Blue Distinction Center for Transplant® (BDCT) are covered at the level of the member's inpatient facility benefit for network providers.
  - Any copayments, deductibles, coinsurance and coinsurance expense limits apply.
  - The benefit includes all organ acquisition costs.
- Transplants performed at non-BDCT, but participating hospitals are covered at the out-of-network inpatient or outpatient facility and professional service benefit levels.
  - Any copayments, deductibles, coinsurance and coinsurance expense limits apply.
  - Except for kidney and bone marrow/stem cell transplants, the maximum benefit for organ harvesting and procurement is $10,000 for each cadaveric organ and up to $45,000 for each organ procured from a living donor (including harvesting). Maximums are subject to copayments, deductibles and coinsurance, if any.
- There are no BDCT facilities for kidney transplants. Kidney transplants are covered at the member's benefit plan's facility and professional benefit levels.
  - Any copayments, deductibles, coinsurance and coinsurance expense limits apply. In the absence of an underlying plan coinsurance expense limit, a $10,000 coinsurance expense limit would apply.
  - Allowable charges for harvesting/procurement for kidneys are determined by Highmark Delaware.
  - Living donor costs are limited to $50,000 (not including harvesting).
- Bone Marrow/Stem Cell Transplants are covered at the member's benefit plan's facility and professional benefit level.
  - Any copayments, deductibles, coinsurance and coinsurance expense limits apply. In the absence of an underlying plan coinsurance expense limit, a $10,000 coinsurance expense limit would apply.

- Allowable charges for donor treatment and harvesting for bone marrow/stem cells are determined by Highmark Delaware.

- Transplants performed at non-participating hospitals are not covered.
- Travel Reimbursement. For transplants that occur at a facility that is located greater than 50 miles from the recipient's home, the following will be covered during the reimbursement period:
  - $150/day limit for reasonable lodging and meals.
  - Ground travel is reimbursed based on the mileage from the recipient's home or temporary lodging to the transplant facility. Reimbursement is calculated using Highmark Delaware's current mileage reimbursement rate.
  - Air travel is reimbursed at the price of the airline ticket (coach class).
  - Tolls and parking incurred while traveling between recipient's home or temporary lodging and transplant facility.
  - There is a $10,000 aggregate limit for all travel costs.

  The reimbursement period begins 5 days prior to a transplant and ends 12 months after the date of transplant. Reimbursement applies to recipient (adult) and one other person. If the recipient is a minor, two adults are covered.

If you have questions about Highmark Delaware's organ transplant policy, please contact the Medical Management and Policy Department at the number listed in the front of this booklet.

To view a list of BDCTs, use the Blue Distinction Center Finder at bcbs.com.

INFERTILITY SERVICES

Artificial Insemination (AI) and Intrauterine Insemination (IUI)

AI and IUI procedures are covered when done as an outpatient. The following limits apply:

- dependent children aren't eligible for infertility services;
- women must be at least age 18 and not have reached their 45th birthday;
- there's a proven infertility problem; and
- the infertility isn't due to voluntary sterilization of either partner.

Charges are paid at the same benefit level as other similar services. If pregnancy results, your maternity benefits are then applied.

In Vitro Fertilization and related procedures

The following procedures are covered when done as an outpatient:

- in vitro fertilization (IVF);
- gamete intrafallopian transfer (GIFT); and
- zygote intrafallopian transfer (ZIFT).

Highmark Delaware must approve your care. Your provider must send Highmark Delaware a completed *Request for IVF Coverage* form, available from **highmarkbcbsde.com** or Customer Service, prior to your beginning treatment.

The criteria listed above for AI and IUI eligibility also apply to IVF and related procedures. In addition, age appropriate AI/IUI procedures must have been previously tried and failed.

Benefit Limits

There's a $10,000 lifetime payment limit for all Infertility Services. The $10,000 limit applies even when you switch to another State of Delaware plan. If pregnancy results, your maternity benefits are then applied.

The following services are included in the $10,000 maximum:

- all surgical procedures;
- office visits;
- lab tests;
- imaging and machine tests;
- hospital services; and
- anesthesia.

Note: Drugs are covered under your prescription drug benefit and are subject to a separate $15,000 limit. Donor services and surrogacy are not covered.

INPATIENT MEDICAL SERVICES

Medical visits by the attending doctor are covered when you're an inpatient. This does not include when you're having surgery. Surgeon pre- and post-operative care is covered under global surgery payment.

We normally cover one doctor visit per day. Usually this is your attending doctor. If another specialist visits you, we may cover the visit, under the following conditions:

- the doctor in charge certifies in writing it's medically necessary;
- the specialist isn't the attending doctor or operating surgeon; and
- the specialist is a doctor.

See the *Mental Health and Substance Abuse Care* section for a description of related doctor visits.

EMERGENCY CARE

You're covered for emergency care in emergency facilities. See the *Emergency and Urgent Care* section for more information.

OBSTETRIC CARE

Obstetric care by doctors and midwives is covered. Coverage is the same as for other surgical and medical care. This includes:

- prenatal care;
- anesthesia;
- delivery; and
- postnatal care.

Midwives are licensed and certified nurses. They must be practicing within the scope of their license. When we cover midwife care, we do not cover a doctor's care for the same services.

One diagnostic ultrasound per pregancy is also covered.

NEWBORN CARE

Medical care for a newborn child is covered, provided the child is enrolled.

See the section entitled "A Guide to Enrollment", *Changes in Enrollment (Newborns)* for more information.

EMERGENCY AND URGENT CARE

Check the *Schedule of Benefits* for benefit levels and any limits that may apply.
Follow managed care requirements to get the highest benefit!

EMERGENCY CARE

If you have a life-threatening emergency, go directly to the nearest emergency provider. We cover the emergency facility, ancillary services and physician care when:

- the condition is serious enough to cause a prudent person to seek emergency care;
- a delay in care might cause permanent damage to your health; and
- you have care within 48 hours from the onset of the condition.

Some examples are:

- broken bones;
- heavy bleeding;
- sudden, severe chest pain;
- poisoning;
- choking;
- convulsions;
- loss of consciousness; and
- severe burns.

Mental Heath and Substance Abuse Emergencies

An emergency mental health or substance abuse condition is one which requires voluntary or involuntary hospitalization because the individual patient is a danger to himself or herself, or to others.

COVERAGE FOR EMERGENCIES:

The facility must be a hospital, or a freestanding emergency facility operating with physicians and nursing personnel on a 24 hour, 7 days per week schedule.

EMERGENCY AMBULANCE AND PARAMEDIC SERVICES

Emergency ambulance and paramedic services are covered when:

- a sudden, serious condition requires travel right away; and
- you are taken to the nearest hospital that can treat you.

When you can travel by private car, the ambulance isn't covered. Only one-way travel to the hospital is covered, except when being transported from hospital to hospital for specialized care. In such cases round trip transportation is covered.

Air ambulance is covered only when no other means of travel is appropriate.

When billed separately, these items are not paid:

- patient care equipment;
- reusable devices; and
- first aid supplies.

Benefits are not provided when paramedic services are given by state, county or local government.

URGENT CARE AND URGENT CARE FACILITIES/MEDICAL AID UNITS

WHEN YOU'RE HOME

Urgent care is for an injury or sudden illness that isn't life threatening, but you need care within a day or two to avoid:

- jeopardizing your life, health, or ability to regain maximum function; or
- in the opinion of your physician, would subject you to severe pain that cannot be adequately managed without the care.

Some examples include ear infections, migraine headaches and significant gastro-intestinal pain.

For urgent care you can either

- see your regular doctor, or
- seek care at an urgent care facility.

An urgent care facility (also known as a medical aid unit) is a medical facility staffed by physicians and other medical personnel equipped to provide treatment of minor illnesses and injuries of an urgent nature which require prompt, but not emergency treatment.

WHEN YOU'RE TRAVELING

If you're traveling out of state and need urgent care, follow these steps:

Step 1

Find a provider. You can call 800.810.BLUE (800.810.2583) to get connected to a 24-hour referral service. This service helps you find doctors who participate with the local Blue Cross Blue Shield plan where you're traveling. If a doctor is found, you're given the doctor's name, office address and phone number.

You can also use the **highmarkbcbsde.com** website to find a provider. The website can access the names, office addresses and phone numbers of network providers nationwide.

Step 2

Call the doctor's office for an appointment and tell them that you're a Highmark Delaware customer. **To get the highest benefit, be sure the provider participates with the local Blue Cross Blue Shield plan.** The doctor's office will check your enrollment. When you receive care, you will be charged the copayment listed on your I.D. card, if any. The doctor's office will then bill the local Blue Cross Blue Shield plan, and the claim will be forwarded to us.

DIAGNOSTIC AND THERAPEUTIC SERVICES

Check the *Schedule of Benefits* for benefit levels and any limits that may apply.
Follow managed care requirements to get the highest benefit!

INPATIENT DIAGNOSTIC AND THERAPEUTIC CARE

When you're an inpatient, professional care for diagnostic and therapeutic care is covered. See the *Inpatient Hospital Care* section for more information.

OUTPATIENT DIAGNOSTIC AND THERAPEUTIC CARE

Remember to use a network provider to get the highest benefits. If you use a non-network provider, even if your doctor refers you, your benefits will be reduced.

DIAGNOSTIC SERVICES

The diagnostic benefits described below apply when you're an outpatient in:

- a provider's office;
- an approved freestanding lab, imaging or machine testing provider; or
- a hospital's outpatient department.

Covered care includes:

- imaging services;
- lab tests; and
- machine tests.

Advanced radiology services, such as CAT and PET scans, MRIs and MRAs are among the imaging services covered. See the *Schedule of Benefits* for more information about the benefit levels for these services. See *Managed Care Requirements* for information about authorization requirements for these services.

PREADMISSION TESTING

We cover tests done before a scheduled admission for surgery.

Tests must be done:

- as an outpatient; and
- within 7 days before the admission.

Tests are not covered if:

- they are done for diagnosis;
- they are repeated after you enter the hospital; or
- you, not the hospital or physician, cancel or postpone the admission.

THERAPY SERVICES

The therapeutic benefits described below apply when you're an outpatient in:

- a provider's office; or
- a hospital's outpatient department.

Covered care includes only:

- chemotherapy by a doctor;
- infusion therapy;
- occupational therapy as called for in your doctor's treatment plan when:
  - needed to help your condition improve in a reasonable and predictable time, or
  - needed to establish an effective home exercise program,
  - the maximum number of visits allowed for a specific diagnosis is determined by medical necessity;
- physical therapy as called for in your doctor's treatment plan when:
  - done by a doctor or licensed physical therapist, and
  - needed to help your condition improve in a reasonable and predictable time, or
  - needed to establish an effective home exercise program,
  - the maximum number of visits allowed for a specific diagnosis is determined by medical necessity;
- radiation therapy for cancer and neoplastic diseases;
- inhalation therapy by a doctor or registered inhalation therapist;
- speech therapy. Therapy must be:
  - done by a licensed or state certified speech therapist,
  - ordered by a doctor, and
  - needed to improve speech problems caused by disease, trauma, congenital defect, or recent surgery,
  - the maximum number of visits allowed for a specific diagnosis is determined by medical necessity;
- dialysis;
- cognitive therapy done by a provider approved by Highmark Delaware. The diagnoses eligible for coverage are:
  - stroke with cognitive impairment, or
  - head injury or trauma;
- cardiac therapy. Services done on an inpatient and outpatient basis are combined to determine when the limit is met. Services must begin within 4 months following certain serious conditions or procedures.

Please note: Your health plan benefit for physical, occupational and speech therapy services includes visit limitations. The maximum number of visits allowed for a specific diagnosis is determined by medical necessity as provided to Highmark Delaware by your treating physician. Highmark Delaware will process the therapy claims according to your benefits, until you reach the visit limitation that is determined to be medically appropriate for your diagnosis. It is important to note that if you exceed the maximum number of visits, your claim(s) will be denied. You will then be responsible for the entire cost associated with the therapy service(s) received.

APPLIED BEHAVIOR ANALYSIS

Benefits are provided for Applied Behavior Analysis for the treatment of autism spectrum disorders in persons under 21 years of age. We may ask for a review of the patient’s treatment once every 12 months.

OTHER COVERED SERVICES

Check the *Schedule of Benefits* for benefit levels and any limits that may apply.
Follow managed care requirements to get the highest benefit!

HOSPICE

Hospice provides palliative and support care to terminally ill patients and their families. Highmark Delaware must authorize the hospice care.

You may have hospice care at home, in an inpatient hospice facility or a short or long term nursing facility for up to 365 days.

What Is Covered Under Hospice:

- care by a hospice doctor;
- nursing care;
- home health aide supervised by a registered nurse;
- social service guidance;
- nutritional counseling and meal planning;
- physical therapy;
- speech therapy;
- occupational therapy;
- spiritual counseling by the hospice;
- medical supplies that are needed to manage the illness;
- prescription drugs related to the palliative management of the patient's terminal illness; and
- bereavement counseling for the family for up to 13 months following the death of the patient.

Some services you have during hospice care are not paid under this benefit. They are paid like other covered benefits, such as:

- care by a non-hospice doctor;
- durable medical equipment (DME) not related to palliative management;
- palliative chemotherapy or radiation therapy when needed to manage the illness;
- inhalation therapy; and
- imaging and lab tests.

What's Not Covered Under Hospice:

- private duty nursing;
- respite care;
- care not prescribed in the approved treatment plan;
- financial, legal or estate planning;
- outpatient prescription drugs other than those for palliative management; and
- hospice care in an acute care facility, except when a patient in hospice care requires services in an inpatient setting for a limited time.

HOME HEALTH CARE

Home health care is covered. The provider and treatment plan must be approved by Highmark Delaware. Medical records or a suitable summary of the progress of the treatment plan must be reviewed by the attending doctor at regular intervals, or at least every 30 days.

Guidelines:

- Care must be needed to treat or stabilize a condition. Care to maintain a chronic condition is not covered.
- There's a limit of one visit per day per specialty. (A nurse and a home health aide count as one specialty for this benefit.)
- Care must be under the direction of a doctor.
- The patient must be home bound and medically unable to get care as an outpatient.
- Care must be in lieu of inpatient care.

What Is Covered Under Home Health:

- skilled nursing care by an RN or LPN;
- therapy by licensed or state certified therapists for:
  - physical therapy;
  - speech therapy; or
  - occupational therapy;
- medical and surgical supplies;
- social service guidance by a licensed or state certified social worker; and
- home health aide when supervised by an RN (limit of 3 visits per week).

What's Not Covered Under Home Health:

- drugs;
- lab tests;
- imaging services;
- inhalation therapy;
- chemotherapy and radiation therapy;
- dietary care;
- durable medical equipment;
- disposable supplies;
- care not prescribed in the approved treatment plan; and
- volunteer care.

HOME INFUSION

Home infusion is home care for receiving needed infusion medicine. It involves the use of an infusion pump with fluids, nutrients and drugs. Highmark Delaware must approve the treatment plan. The plan must be prescribed by a doctor in lieu of inpatient care.

What Is Covered Under Home Infusion:

- nursing care;
- medications (includes drug preparation and monitoring);
- solutions; and
- infusion pumps, poles and supplies.

What's Not Covered Under Home Infusion:

- delivery costs;
- record keeping costs;
- doctor management;
- other services which do not involve direct patient contact; and
- drugs normally covered under a drug program.

INPATIENT PRIVATE DUTY NURSING

Private duty nursing care is covered when you are an inpatient in an acute hospital. We may review the case in advance. We may review the case again after 80 hours of care. Care must be:

- ordered by the attending doctor;
- for the same condition you're hospitalized for; and
- approved by the hospital.

This care isn't covered when done in special care units of the hospital, such as:

- self-care units;
- selective care units; and
- intensive care units.

This care isn't covered when done as a convenience even if authorized by your doctor.

DOCTOR'S VISITS

Visits with a doctor in the office or your home are covered. This includes visits for injury or illness.

Unless stated on the *Schedule of Benefits*, routine physical exams and tests are not covered.

SPECIALIST/REFERRAL CARE

Home and office visits with specialists are covered. This includes visits for injury or illness.

DIABETIC EDUCATION

Diabetic education provides instruction on the care and treatment of diabetes, including foot care, eye exams for diabetic retinopathy, blood sugar monitoring, medication management and diabetic nutritional counseling. Diabetic education can be performed by either physicians or Certified Diabetic Educators, either on an individual basis or in a group setting.

NUTRITIONAL COUNSELING

Services are provided for the assessment and guidance of members at nutritional risk due to nutritional history, current dietary intake, medication use or chronic illness. Nutritional counseling is indicated for certain diagnoses, including diabetes, malnutrition, eating disorders and cardiovascular disease.

Nutritional counseling benefits are not provided for weight loss in the absence of co-morbid conditions, or for conditions that have not been shown to be nutritionally related, including, but not limited to, chronic fatigue syndrome and hyperactivity.

ALLERGY TESTING AND TREATMENT

Allergy testing and treatment are covered.

CHIROPRACTIC CARE

Please note: Your health plan benefit for chiropractic services includes visit limitations. The maximum number of visits allowed for a specific diagnosis is determined by medical necessity as provided to Highmark Delaware by your treating physician. **In addition, services are limited to 30 visits per plan year regardless of medical necessity**. Highmark Delaware will process the chiropractic claims according to your benefits, until you reach the visit limitation that is

determined to be medically appropriate for your diagnosis or the plan year limit for the diagnosis, whichever is less. It is important to note that if you exceed the maximum number of visits, your claim(s) will be denied. You will then be responsible for the entire cost associated with the chiropractic service(s) received.

The following care is covered when done by a licensed chiropractor for the treatment of spinal and extraspinal conditions:

- office visit for initial evaluation;
- manual manipulation of the spine, head, rib cage, abdomen and upper and lower extremities; and
- physical therapy, including ultrasound, traction therapy, and electrotherapy.

Chiropractic coverage is limited to three modalities per visit and one visit per day. Other limits are listed on the *Schedule of Benefits*.

Chiropractic services must either provide significant improvement in your condition in a reasonable and predictable period of time or be necessary to establish an effective home exercise program. Chiropractic services that are part of a maintenance program are not covered.

Chiropractic X-rays are covered only for X-rays of the spine. Cervical x-rays and thoracic x-rays are covered; full spine x-rays are not covered.

Durable medical equipment (DME) is covered. This includes cervical collars and lumbar sacral supports. These are covered under your DME benefit.

Machine tests are covered under your Therapeutic and Diagnostic Services benefit.

DURABLE MEDICAL EQUIPMENT & PROSTHETICS

Durable Medical Equipment

Covered durable medical equipment (DME) includes items that are:

- prescribed by a doctor;
- useful to a person only during an illness or injury; and
- deemed by Highmark Delaware to be medically necessary and appropriate.

Some examples of DME are:

- orthopedic braces;
- wheel chairs;
- orthotics; and
- hospital beds.

We may pay for rent or purchase. If we rent the equipment, our total payment won't exceed the purchase price.

Prosthetics

Covered prosthetics includes items that are

- intended to replace all or part of an organ or body part lost to disease or injury, or absent from birth, or permanently inoperative or malfunctioning;
- prescribed by a qualified provider;
- removable and attached externally to the body; and
- deemed by Highmark Delaware to be medically necessary and appropriate.

Some examples of prosthetics are:

- hair prostheses for hair loss caused by chemotherapy or alopecia areata resulting from an autoimmune disease;
- limb, ear, or eye prostheses; and
- electro-larynx devices.

We also pay to replace or repair prosthetic devices.

We also pay for:

- medical foods and formula for the treatment of inherited metabolic disorders; and
- hearing aids. Benefits are limited to one hearing aid, per ear, every three (3) years for children less than 24 years of age.

DME & Prosthetics Not Covered:

- items for comfort or convenience;
- dental prosthetics; and
- foot orthotics.

CARE FOR MORBID OBESITY

Patients who are overweight and have serious, weight-related diseases, such as hypertension, type II diabetes, and cardiac disease, are considered morbidly obese.

If you are morbidly obese, we cover the following:

- Office visits – payable on the same basis and at the same reimbursement level as other covered outpatient physician visits.
- Laboratory tests - payable on the same basis and at the same reimbursement level as other covered outpatient laboratory services.

Surgical treatment of morbid obesity is covered when certain conditions are met. All such care must be approved by Highmark Delaware.

SURGERY FOR MORBID OBESITY

See the section below, *Blue Distinction Centers for Bariatric Surgery*, for information about how surgery for morbid obesity is paid.

If you are morbidly obese, we cover the following surgical procedures:

- gastric bypass;
- gastric stapling;
- biliopancreatic bypass with duodenal switch;
- gastric banding; and
- sleeve gastrectomy.

You must:

- have achieved full growth and be 18 years or older (members under age 18 may also qualify under certain circumstances);
- have no specific, treatable, correctable cause for the morbid obesity (e.g., endocrine disorder);
- complete a structured diet program in the 2-year period that immediately precedes the request for the surgery;

- have received a psychological evaluation specifically for the diagnosis of obesity or morbid obesity;
- have received appropriate medical clearances for the surgery; and
- meet any of the following criteria:
  - you weigh at least 100 pounds above or are twice the ideal body weight; or
  - have a body mass index (BMI) of at least 40 (at least 50 for sleeve gastrectomy and biliopancratic bypass with duodenal switch); or
  - have a BMI equal or greater than 35, in conjunction with one or more of the following co-morbid conditions: degenerative joint disease, hypertension, coronary artery disease, diabetes, sleep apnea, lower extremity venous/lypmphatic obstruction, obesity related pulmonary hypertension.

Your BMI is calculated by dividing your weight in pounds by your height in inches squared, then multiplying the result by 704.5.

Blue Distinction Centers for Bariatric Surgery (BDCBS)

See the *CDH Gold Schedule of Benefits* for information about benefit levels. You will receive the highest level of benefit for surgery for morbid obesity if you use a BDCBS.

A BDCBS provides a full range of bariatric surgery care services, including inpatient care, post-operative care, outpatient follow-up care and patient education. These centers have demonstrated their commitment to quality care, resulting in better overall outcomes for bariatric patients.

To view a list of BDCBS, use the Blue Distinction Center Finder at bcbs.com.

If you use a network provider other than a BDCBS, your benefits will be reduced. See the *CDH Gold Schedule of Benefits* for more information.

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

Check the *Schedule of Benefits* for benefit levels and any limits that may apply.
Follow managed care requirements to get the highest benefit!

This plan provides benefits for the treatment of behavioral health disorders, including mental illness and substance abuse. For inpatient care, managed care requirements must be followed.

INPATIENT HOSPITAL CARE

Inpatient hospital care is covered on an emergency or planned basis. The following services are covered when you're in the hospital:

Room And Board

Room and board, special diets and general nursing care are covered. Payment is made at the semiprivate room rate. If you have a private room, you pay the extra charge above the semiprivate rate. We cover private rooms only when medically necessary.

Other Hospital Care

When medically necessary, we cover:

- electroconvulsive therapy by a doctor;
- detoxification;
- drugs listed in the U.S. Pharmacopoeia or National Formulary; and
- lab tests.

PARTIAL HOSPITAL CARE

This plan also covers partial hospital programs. A partial hospital program provides an intermediate level of care as an alternative to inpatient hospitalization or as an option following inpatient hospitalization. Partial hospital programs generally are provided within a psychiatric hospital or behavioral health department of a hospital.

INTENSIVE OUTPATIENT CARE

Intensive outpatient care in a free-standing or hospital-based program is covered. Intensive outpatient programs provide a step down from acute inpatient or partial hospitalization, or a step up from outpatient care in office settings.

OUTPATIENT CARE – OFFICE VISITS

Outpatient care covers:

- brief crisis intervention psychotherapy;
- psychiatric consultations;
- supportive psychotherapeutic treatment; and
- psychological tests (limit of 8 hours of tests per year).

Care must be by a network provider such as a:

- doctor;
- licensed clinical psychologist;
- licensed professional counselor of mental health (LPCMH);
- licensed clinical social worker; or
- nurse practitioner.

Care must be done in the provider's office or as a hospital outpatient.

WHAT IS NOT COVERED

The following services and items are not covered.

- Acupuncture.
- Ancillary services (including but not limited to, office visits, physician care, lab and radiology procedures and prescription drugs) in conjunction with a non-covered service.
- Biofeedback.
- Blood, blood components and donor service.
- Care as a result of any criminal act in which you conspired or took part. One example is Highmark Delaware does not pay for the court mandated instruction course or rehabilitation program resulting from driving under the influence of alcohol or drugs.
- Care, unless required by law, by:
  - a school infirmary;
  - a student health center; or
  - staff working at the above.
- Care for cosmetic reasons.
- Care for complications or consequences of services and items not covered.
- Care for weight loss, unless co-morbid conditions are present.
- Care given by a family member. "Family" means yourself, your parents, your children, your spouse or your siblings.
- Care given by any person living with you.
- Care given by institutions or agencies owned or operated by the government, unless the law requires otherwise.
- Care given by your employer's health department.
- Care needed through an act of war if the war occurred after this plan became effective.
- Care needed through service in the armed forces of any country.
- Care not directly related to, and necessary for, the diagnosis or treatment of illness or injury. Care must:
  - be consistent with the symptom or treatment of the condition;
  - meet the standard of accepted professional practice;
  - not be solely for anyone's convenience; and
  - be the most appropriate supply or level of care safely provided. For inpatient care, it means care cannot be safely provided as an outpatient.
- Care we consider to be experimental or investigational. Some examples are:
  - care we consider not to be accepted medical practice; and
  - care that requires government agency approval, and the approval hasn't been granted.

Routine care costs related to approved clinical trials, as determined by Highmark Delaware, are covered.

- Care you can have without charge in the absence of insurance.
- Certain mental health services, including:
  - aptitude tests;
  - testing and treatment for learning disabilities;
  - treatment for personality disorders;
  - treatment factitious disorders;
  - treatment of sleep disorders;
  - treatment of sexual and gender identity disorders;
  - care beyond that needed to determine mental deficiency or retardation;
  - marital/relationship counseling; and
  - care at behavioral health facilities or in residential programs.
- Change of sex surgery, except to correct congenital defect, or any medical services related to gender identity disorder.
- Computerized gait analysis or electrodynographic tests.
- Convenience items. Some examples are:
  - phones;
  - TVs;
  - radios; and
  - other personal items.
- Dental care, except certain dental care noted in the *Surgical and Medical Benefits* section.
- Drugs or care received in violation of law.
- Enteral nutrition ingested or administered orally, even if it is the sole nutritional source. The only exceptions are certain medical foods prescribed for inherited metabolic disorders.
- Exams or tests done as inpatient for convenience when such care could be done as outpatient.
- Eye or hearing exams, unless noted elsewhere in this booklet.
- Eyeglasses, contact lenses and all procedures for refractive correction.
- Hearing aids for members age 24 and over.
- Immunization or inoculations, unless noted elsewhere in this booklet. Immunizations or inoculations for travel are not covered, except as required by law.
- Injury or illness on the job. One example is any care normally covered under Workers' Compensation or occupational disease laws.
- Items or services that can be purchased without a prescription, unless noted elsewhere in this booklet. Some examples are:
  - Blood pressure cuffs;
  - Contraception, first aid and other medical supplies;
  - Exercise equipment; and
  - Incontinence and personal hygiene supplies.

- Methadone.
- Occupational or physical therapy for developmental delay.
- Orthotic equipment and devices for feet. Some examples are:
  - foot inserts;
  - arch supports;
  - lifts; and
  - corrective shoes.
- Physical exams, or any other services or treatments required by or intended for:
  - potential employers or licensing authorities (for example, marriage physicals);
  - insurers;
  - schools or camps;
  - courts or legal representatives; or
  - any other third party.
- Prescription drugs, even if your doctor writes you a prescription.
- Rest cures, custodial care or homelike care even when prescribed by a doctor.
- Routine foot care.
- Services in excess of your covered benefit limits.
- Speech therapy for:
  - attention disorders;
  - behavior problems;
  - conceptual handicaps;
  - learning disabilities; and
  - developmental delays.
- Substance abuse treatment in residential facilities.
- Surgery to reverse voluntary sterilization.
- Thermography.
- Treatment of developmental delay unless there is an identifiable underlying cause.
- Treatment of Temporomandibular Joint (TMJ) Dysfunction Syndrome, unless there is documented organic joint disease, or joint damage resulting from physical trauma. This includes exams for fittings, occlusal adjustment and TMJ devices.
- Vision therapy and orthoptics.
- Unless otherwise noted in this booklet, we cover one service per day by a professional provider. If more than one service is done, we cover only the service with the greater allowable charge.

VALUE ADDED FEATURES

Highmark Delaware offers Value Added Features. They are described below.

Value Added Features are administered only as specified in the Highmark Delaware Value Added Features materials.

Please note: Highmark Delaware has the right to change or discontinue these programs at any time.

EYEWEAR DISCOUNTS

On behalf of Highmark Delaware, your eyewear discount program is administered by Davis Vision, an independent managed vision care company.

You can save money on eyewear by going to one of the program's participating providers. To get a list of participating providers and the products subject to discount, call 888.235.3119 (TTY: 800.523.2847) or visit **www.davisvision.com**. The client code is 2722.

DISCOUNT PROGRAMS

Savings on a variety of product and services are available to Highmark Delaware members, including:

- Fitness clubs
- Alternative health services (i.e., acupuncture, chiropractic care)
- Laser vision corrective surgery
- Hearing aids

For a full listing of our discounts go to **highmarkbcbsde.com** or call us at 800.633.2563

YOUR RIGHTS AND RESPONSIBILITIES

As a Highmark Delaware member, you have certain rights and responsibilities. Please review them. Please call us if you have any questions.

You have the RIGHT to:

- Be treated with courtesy, consideration, respect and dignity.
- Have your protected health information (PHI) and health records kept confidential and secure, in accordance with applicable laws and regulations.
  - Receive communications about how Highmark Delaware uses and discloses your PHI.
  - Request restrictions on certain uses and disclosures of your PHI.
  - Receive confidential communications of PHI.
  - Inspect, amend and receive a copy of certain PHI.
  - Receive an accounting of disclosures of PHI.
  - File a complaint when you feel your privacy rights have been violated.
- Available and accessible services when medically necessary, including urgent and emergent care 24 hours a day, seven days a week.
- Receive privacy during office visits and treatment.
- Refuse care from specific practitioners.
- Know the professional background of anyone giving you treatment.
- Discuss your health concerns with your health care professional.
- Discuss the appropriateness or medical necessity of treatment options for your condition, regardless of cost or benefit coverage for those options.
- Receive information about your care and charges for your care.
- Receive from your provider, in easy to understand language, information about your diagnoses, treatment options including risks, expected results and reasonable medical alternatives.
- All rights afforded by law or regulation as a patient in a licensed health care facility, including the right to refuse medications and treatment after possible consequences of this decision have been explained to you in your primary language.
- Receive information about Highmark Delaware, its policies, procedures regarding its products, services, practitioners and providers, complaint procedures, and members'/enrollees' rights and responsibilities.
- Play an active part in decisions about your health care including formulating an advance directive.
- Receive benefits and care without regard to race, color, gender, country of origin, or disability.
- File a complaint with Highmark Delaware and receive a response to the complaint within a reasonable period of time.
  - This includes requesting an internal appeal or review by an Independent Utilization Review Organization. To register a complaint or request an appeal members are instructed to call the Customer Service number listed on their ID card.
- Submit a formal complaint about the quality of care given by your providers.

- Make recommendations regarding Highmark Delaware's members' rights and responsibilities policies.

You have the RESPONSIBILITY to:

- Double-check that any facilities from which you receive care are covered by Highmark Delaware. Visit **highmarkbcbsde.com** or call the Customer Service number listed on your ID card to ask about a facility.
- Show your ID card to all caregivers before having care.
- Keep your appointments. If you will be late or need to cancel, give timely notice (in accordance with your provider's office policy). You may be responsible for charges for missed appointments.
- Treat your providers with respect.
- Provide truthful information (to the extent possible) about your health to your providers. This includes notifying your providers about any medications you are currently taking.
- Understand your health and participate in developing mutually agreed upon treatment goals.
- Tell your health care providers if you don't understand the care he or she is providing.
- Follow the advice of your health care provider for medicine, diet, exercise and referrals.
- Follow the plans and instructions for care that you have agreed on with your practitioners.
- Pay all fees in a timely manner.
- Maintain your Highmark Delaware eligibility. Notify us of any change in your family size, address or phone number.
- Tell Highmark Delaware about any other insurance you may have.

A GUIDE TO ENROLLMENT INFORMATION

The information presented in this section is subordinate to Delaware Code and the Group Health Plan Eligibility and Enrollment Rules. In the event of conflict, Delaware Code and the Group Health Plan Eligiblilty and Enrollment Rules are controlling.

WHO IS COVERED

WHO CAN BE COVERED

Your plan may cover:

- You;
- Your spouse; and
- Your children.

NOTE: The State of Delaware requires proof of dependency. See the section *Changes in Enrollment*, below, for the documentation required to enroll dependents. Highmark Delaware will require proof of disability through the completion of the *Disabled Child Application* available at **highmarkbcbsde.com**.

TYPES OF ENROLLMENT

You may enroll in one of these coverage types:

- **Employee** for you only;
- **Employee and Child(ren)** for you and your children;
- **Employee and Spouse** for you and your spouse; or
- **Family** for you, your spouse and your children.

YOU ARE ELIGIBLE TO BE COVERED IF:

- you are a regular officer or employee of the State;
- you are a regular officer or employee of a State agency or school district;
- you are a pensioner already receiving a State pension;
- you are a pensioner eligible to receive a State pension;
- you are a per diem and contractual employee of the Delaware General Assembly and have been continuously employed for 5 or more years;
- you are a regularly scheduled full-time employee of any Delaware authority or commission participating in the State's Group Health Insurance Program;
- you are a regularly scheduled full-time employee of the Delaware Stadium Corporation or the Delaware Riverfront Corporation;
- you are a paid employee of any volunteer fire or volunteer ambulance company participating in the State's Group Health Insurance Program;
- you are a regularly scheduled full-time employee of any county, soil and water conservation district or municipality participating in the State's Group Health Insurance Program;
- you are receiving or eligible to receive retirement benefits in accordance with the Delaware County and Municipal Police/Firefighter Pension Plan with Chapter 88 of Title 11 of the Delaware Code or the county and municipal pension plan under Chapter 55A of Title 29 of the Delaware Code.

As used throughout this booklet, the term *employee* refers to any person described in the above list. The only exception to this is found in the section *Coordination of Benefits*, where, in limited context, the term may refer to a spouse.

SPOUSE

You may enroll your spouse. A *spouse* is one of two persons united together in either:

- a marriage; or
- a civil union;

that is recognized by and valid under Delaware law.

Information on civil unions, including Frequently Asked Questions (FAQ), tax dependent status, coverage codes, health plan rates and enrollment is available at:

http://www.ben.omb.delaware.gov/cu

SPOUSE'S BENEFITS

This is how we pay benefits for spouses enrolled under this Plan:

- We pay normal plan benefits if your spouse isn't employed.
- We pay after your spouse's plan pays if your spouse:
  - is eligible for; and
  - **is enrolled** in a plan sponsored by his or her employer or by an organization from which he or she is collecting a pension benefit.
- We pay 20% of allowable covered charges if your spouse:
  - is eligible for; and
  - **is not enrolled** in a plan sponsored by his or her employer or by an organization from which he or she is collecting a pension benefit.

The combined payments can't be more than 100% of covered charges. For more details, see the section, *Coordination of Benefits*.

The above will not apply if your spouse is not enrolled in the plan sponsored by his/her employer or by an organization from which he or she is collecting a pension benefit, because your spouse:

- doesn't work full-time;
- isn't eligible because he/she doesn't work enough hours to be eligible;
- isn't eligible because he/she hasn't completed a waiting period;
- has to pay more than half of the plan's cost (including flexible credits);
- doesn't meet the underwriting requirements of the sponsored plan; or
- the employer or sponsoring organization doesn't offer active or retiree health coverage.

Members are responsible for completing a *Spousal Coordination of Benefits* form each year, or at any time a spouse's job or health coverage status changes. The electronic *Spousal Coordination of Benefits* form is available at https://secomb.delaware.gov/cob/. This form must be completed and submitted online.

CHILDREN

To be covered, a child must be

- age 26 or younger, and
- either
  - born to the employee or his or her spouse,
  - adopted by the employee or his or her spouse,
  - placed in the home of the employee or his or her spouse for adoption, or

- someone for whom health care coverage is the employee's or his or her spouse's responsibility under the terms of a qualified medical child support order. A copy of the order must be provided to your Human Resources/Benefits Office.

You are required to submit proof of relationship, such as a birth certificate or adoption papers.

Coverage for Other Children

You may also cover a child who is not your or your spouse's natural or adoptive child if the child is:

- unmarried; and
- living with you in a regular parent-child relationship; and
- dependent upon you for support, and qualifies as your dependent under Internal Revenue Code §105 and §152; and
- is under age 19; or
- is under age 24 if a full-time student.

For each child, you are required to show proof of dependency, such as a birth certificate, court order, or federal tax return. The applicable documents must be provided to your Human Resources/Benefits Office upon enrollment. You must request enrollment within 30 days of the date the child became eligible.

You must also submit a *Statement of Support* form to verify you provide at least 50 percent support for the child upon enrollment and any time there are changes to the support you provide. The *Statement of Support* form is available at **http://ben.omb.delaware.gov/medical/bcbs/** Please print the form, complete it, and provide to your Human Resources/Benefits Office.

You must also submit a *Full-Time Student Certification* form for each child between the ages of 19 and under age 24, when the child is initially eligible as a full-time student, each time the child's student status changes, and for each school semester. The *Full-Time Student Certification* form is available at **http://ben.omb.delaware.gov/medical/bcbs/** Please print the form, complete it, and provide to your Human Resources/Benefits Office.

DISABLED CHILDREN

A Disabled child can be covered after the dependent child age limits. He/she may be covered if:

- he/she was covered continuously as a dependent child by a group plan through his/her parent before reaching the dependent child age limit;
- he/she is not married;
- he/she provided 50% or less of his/her own support because of a disability that is expected to last more than 12-months or result in death;
- his/her disability occurred before he/she reached the dependent child age limit;
- he/she is not eligible for coverage under Medicare, unless federal or state law requires otherwise.

Other rules may apply in the case of divorced parents.

You must file a *Disabled Child Application* form with Highmark Delaware. You may get the form online at **http://ben.omb/delaware.gov/medical/bcbs/index.shtml or at highmarkbcbsde.com.** You must print the form, complete it, obtain physician's information and signature, and mail the form to Highmark Delaware at the address provided on the form.

ENROLLMENT

HOW TO ENROLL

You may enroll yourself and your dependents when you are first eligible or at Open Enrollment by completing the enrollment process as designated by your Human Resources/Benefits Office. If you want to cover your spouse, you'll need to complete the *Spousal Coordination of Benefits Form*. The form is available at **https://secomb.delaware.gov/cob**. This form must be completed and submitted online.

HOW TO DECLINE COVERAGE

You may decline coverage if you don't want to enroll when you're first eligible. You will need to complete the enrollment process indicating you are waiving coverage as designated by your Human Resources/Benefits Office.

WHEN COVERAGE BEGINS

When your coverage begins is determined by:

- when you are eligible for coverage; and
- when you enroll for coverage.

There are three categories of enrollees based on when you enroll for coverage. You can be a:

- Timely Enrollee;
- Special Enrollee; or
- Late Enrollee.

TIMELY ENROLLEES

Who Can Be A Timely Enrollee

You are a Timely Enrollee if you enroll within 30 days (31 days for newborns) of when you are first eligible to be covered.

When Coverage Begins

Coverage for new employees (and their dependents) begins:

- on the first of the month following the employee's date of hire; or
- on the first of the month following the completion of three months of service when an employee moves to a class that is eligible for health coverage.

SPECIAL ENROLLEES

Who Can Be A Special Enrollee

Please also refer to the section *Changes in Enrollment*, below, for qualifying events that trigger Special Enrollment status.

You are a Special Enrollee if you enroll within the 30-day (31 days for newborns) enrollment period. The enrollment period is measured from the date of the qualifying event, such as:

- losing other health coverage under certain conditions; or
- obtaining a new dependent because of marriage, civil union, birth (enrollment period is 31 days, see section below entitled *Changes in Enrollment, Newborns*), adoption or placement in the home for adoption, or court ordered support.

Employees or dependents may qualify as Special Enrollees if the following requirements are met:

- Employees: if you're not already enrolled in this Plan, you must:
  - be eligible to enroll in this Plan; and
  - enroll at the same time you enroll a dependent.
- Spouses and Children: you're a dependent of an employee:
  - who is already enrolled or is eligible to enroll in this Plan; and
  - who enrolls at the same time you enroll.

If you don't request enrollment within the enrollment period, you are a Late Enrollee.

Loss Of Other Coverage

To qualify as a Special Enrollee because of loss of coverage, you (the employee or dependent) must meet all these conditions:

- you were covered under another group or individual health plan when coverage was previously offered under this Plan (when first eligible or during Open Enrollment); and
- when this Plan was previously offered, you declined coverage under this Plan because you had other coverage; and
- the other coverage was either:
  - COBRA continuation coverage that is exhausted; or
  - other (non-COBRA) coverage that was lost because
    - you are no longer eligible; or
    - the lifetime limits under the other coverage were reached, or
    - the employer stopped contributing; and
- you enrolled within 30 days of the date the other coverage was lost; and
- you can prove the loss of the other coverage by providing proof of coverage, such as a *Certificate of Coverage*.

Special Enrollment Rights for Loss of Medicaid or Children's Health Insurance Program (CHIP) Enrollment

Effective April 1, 2009, you may enroll within 60 days of the date your Medicaid or CHIP coverage was terminated because you were no longer eligible.

New Dependents

You (employee or dependent) are a Special Enrollee if the employee gets a new dependent because of:

- marriage or civil union;
- birth;
- adoption;
- placement of a child in the home for adoption; or
- court-ordered support.

When Coverage Begins

Coverage for Special Enrollees begins as follows. If the Human Resources/Benefits Office was notified of a loss of coverage or new dependent within 30 days and your application and premium is subsequently submitted, coverage begins for:

- Employees: the first day of the month after the loss of coverage.

- Spouses: either the date of marriage or civil union or the first day of the month after the marriage or civil union.
- Children: either:
  - the date of birth, adoption or placement in the home for adoption; or
  - the first day of the month after you request enrollment if:
    - you lost coverage under a prior plan; or
    - your parent got married or entered into a civil union.

Remember, if you request enrollment after the enrollment period, you (and your dependents) will be Late Enrollees!

LATE ENROLLEES

Who Can Be A Late Enrollee

If you did not enroll as a Timely or Special Enrollee, you are a Late Enrollee. Late Enrollees can enroll at an Open Enrollment period.

Children are Late Enrollees if enrollment was not requested within 30 days of:

- birth (31 days);
- adoption;
- placement in the home for adoption; or
- marriage or civil union.

When Coverage Begins

Coverage for Late Enrollees begins the first day of the new plan year.

CHANGES IN ENROLLMENT (ALSO SEE *WHEN COVERAGE ENDS*)

You can change your enrollment because of one of the reasons described below. *If added premium is due, you must pay when you enroll.*

You must enroll yourself (and any dependents) within a 30-day period from the dates of the events listed below to be Special Enrollees. You and/or your dependent(s) will be Late Enrollees if you are not enrolled within the 30-day period. Newborns must be enrolled within a 31-day period. See your Human Resources/Benefits Office.

MARRIAGE OR CIVIL UNION

You may add your spouse when you get married or enter into a civil union. You must request enrollment within 30 days after the marriage or civil union; a copy of your marriage or civil union certificate is required by your Human Resources/Benefits Office. If added premium is due, you must pay when you request enrollment.

Don't forget, when you cover your spouse you'll also need to complete the *Spousal Coordination of Benefits Form.* The form is available at **https://secomb.delaware.gov/cob**. This form must be completed and submitted on-line each year, or any time a spouse's job or health coverage status changes.

You may also add any stepchildren you acquire when you marry or enter into a civil union. See section describing coverage for *Other Children*, below.

DIVORCE

Former spouses aren't eligible for coverage under this program. See the section, *When Coverage Ends*, below for information about disenrolling a former spouse.

NEWBORNS

You may add your newborn child. Coverage for a child born to a regular officer, employee, eligible pensioner or spouse will be begin on the date of birth, provided:

- you request enrollment of the child within 31 days of the date of birth; and
- the necessary paperwork, including a valid copy of the child's birth certificate, is provided to the Human Resource/Benefits Office with 31 days of the enrollment request; and
- if applicable, you change your coverage to a type that includes children, and pay any additional premium.

Where an employee has existing coverage that includes children, the 31-day time restriction does not apply, but the child must be enrolled for claims to be paid.

ADOPTED CHILDREN

You may add a child because of adoption or placement in the home of a regular officer, employee, eligible pensioner, or his or her spouse for adoption. A birth certificate or legal documentation needs to be supplied to your Human Resources/Benefits Office. You must request enrollment within 30 days of the date the child became eligible.

OTHER CHILDREN

You may add a child other than a newborn or adopted child, such as a step-child. For each child, you are required to show proof of dependency, such as a birth certificate, court order, or federal tax return. The applicable documents must be provided to your Human Resources/Benefits Office upon enrollment. You must request enrollment within 30 days of the date the child became eligible.

You must also submit a *Statement of Support* form to verify you provide at least 50 percent support for the child upon enrollment and any time there are changes to the support you provide. The *Statement of Support form* is available at **http://ben.omb.delaware.gov/medical/bcbs/** Please print the form, complete it, and provide to your Human Resources/Benefits Office.

You must also submit a *Full-Time Student Certification* form for each child between the ages of 19 and under age 24, when the child is initially eligible as a full-time student, each time the child's student status changes, and for each school semester. *The Full-Time Student Certification* form is available at **http://ben.omb.delaware.gov/medical/bcbs/** Please print the form, complete it, and provide to your Human Resources/Benefits Office.

WHEN CONTINUATION OF COVERAGE UNDER COBRA ENDS

You may have declined coverage under this Plan when you were first eligible because you chose to keep COBRA coverage with another plan. If you enroll in this Plan before your COBRA continuation coverage is exhausted, you will be a Late Enrollee.

When your COBRA continuation coverage is exhausted, you may enroll in this Plan.

MEDICARE ELIGIBILITY AND ENROLLMENT

You are eligible to enroll in Medicare Parts A and B when you turn age 65, or earlier if you become disabled. Your spouse is similarly eligible. In accordance with 29 Delaware Code § 5203(b) and the State of Delaware's Group Health Insurance Program's Eligibility and Enrollment Rule 4.08, you and your spouse must enroll in Medicare upon eligibility. Failure to enroll and maintain enrollment in Medicare Parts A and B when eligible may result in you, as the subscriber, being held responsible for the cost of the claims incurred, including prescription costs, for you and your spouse. The following information is for you and your spouse.

Medicare Part A helps cover inpatient care in hospitals and is provided at no charge to you. Medicare Part B helps cover doctors' and other health care providers' services, outpatient care, durable medical equipment, and home health care, and is provided at a monthly cost to you as determined by the Social Security Administration.

Active Employees and Spouses

If you are a benefit eligible active employee, or the spouse of a benefit eligible active employee, about three months before turning age 65:

- Contact your local Social Security Administration Office and apply for Medicare Part A;
- Advise your Human Resources/Benefits Office that you have applied;
- When you receive your Medicare Part A identification card, provide your Human Resources/Benefits Office with a copy.

Active employees and their spouses who are age 65 or older have a right to decide which medical plan will be their primary insurer: either the employer health plan or Medicare. If you or your spouse selects Medicare as primary, the State cannot offer or subsidize a health plan to supplement Medicare's benefits. If you choose, Highmark Delaware may remain your primary plan while you are an active employee.

Important note: When you retire you will be required to have Medicare Part B in addition to Part A. Therefore, you should apply for Medicare Part B about three months before retirement.

Retiring or Retired Employees and Spouses

You must apply for Medicare Part B about three months before you retire for it to be effective upon retirement.

If you are a State of Delaware pensioner, or the spouse of a State of Delaware pensioner, about three months before turning age 65:

- Contact your local Social Security Administration Office and apply for Medicare Parts A and B;
- Advise the State's Office of Pensions that you have applied;
- When you receive your Medicare Parts A and B identification card, provide the State's Office of Pensions with a copy. The Office of Pensions will enroll you in a Medicare Supplement plan, *Special Medicfill*, to help cover costs not covered by Medicare Parts A and B.

If you are a State of Delaware pensioner, or the spouse of a State of Delaware pensioner, and are disabled or become disabled, even though you are not age 65:

- Contact your local Social Security Administration Office and apply for Medicare Parts A and B;
- Advise the State's Office of Pensions that you have applied;
- When you receive your Medicare Parts A and B identification card, provide the State's Office of Pensions with a copy. The Office of Pensions will enroll you in a Medicare Supplement plan, *Special Medicfill*, to help cover costs not covered by Medicare Parts A and B.

If you are denied enrollment in Medicare Parts A and/or B, you are required to appeal, and provide both a copy of the denial and your appeal to the State's Office of Pensions. Failure to enroll and maintain enrollment in Medicare Parts A and B when eligible may result in you, as the subscriber, being held financially responsible for the cost of the claims incurred, including prescription costs, for you and your spouse. Should Medicare deny your appeal, and you provide a copy of the denial to the State's Office of Pensions, then you will continue to be covered under your Highmark Delaware plan with the State's Group Health Insurance Program.

Other Considerations – Disability, ESRD and ALS

The classification of being "disabled" by the State of Delaware as it relates to your ability to perform your job for the State of Delaware (or another employer for a spouse) may differ from the classification of being "disabled" by the Social Security Administration. It is always your responsibility to provide the State's Office of Pensions with your current classification by the Social Security Administration.

There are special Medicare rules regarding some health conditions, such as End Stage Renal Disease (ESRD) and Amyotrophic Lateral Sclerosis (ALS, also known as Lou Gehrig's Disease). Generally, you may apply to have the standard 24-month Medicare eligibility waiting period waived if you have been diagnosed with either of these conditions. Upon receiving a diagnosis of either of these conditions, whether you are an active employee, pensioner or spouse, you should contact your local Social Security Administration Office or visit ssa.gov for more information.

HIPAA CERTIFICATE OF CREDITABLE COVERAGE

A federal law called the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that the State of Delaware Group Health Insurance Program (the "Plan") provide a Certificate of Creditable Coverage (a "Certificate") to each individual who requests one, so long as it is requested while the individual is covered under the Plan or within 24 months after the individual's coverage under the Plan ends. A certificate will also be automatically issued upon the termination of any individuals covered under the Plan, whether or not a request is made. The request can also be made by someone else on behalf of an individual. For example, an individual who previously was covered under this Plan may authorize a new health plan in which the individual enrolls to request a Certificate from this Plan. An individual is entitled to receive a Certificate upon request even if the Plan has previously issued a Certificate to that individual.

Requests for Certificates should be directed to your organization's Human Resources/Benefits Office.

All requests must include:

- The name of the individual for whom the Certificate is requested;
- Where a certificate is requested for a dependent individual, the name of the participant who is enrolled in the Plan;
- A telephone number to reach the individual for whom the Certificate is requested or the participant who enrolled the individual, in the event of any difficulties or questions.

- The name of the person making the request and evidence of that person's authority to request and receive the Certificate on behalf of the individual;
- The address to which the Certificate should be mailed; and
- The requester's signature.

After receiving a request that meets these requirements, your organization's Human Resources/Benefits Office will send a request to the State of Delaware COBRA/HIPAA Administrator to provide the Certificate as soon as administratively feasible.

WHEN COVERAGE ENDS

The State of Delaware COBRA Administrator will provide you and your dependents with a standard *Certificate of Coverage* when you lose coverage under this Plan. Also, you have up to 24 months following the loss of coverage to request a certificate. The *Certificate of Coverage* will show how long you were covered under this Plan.

Please read the section, *Continuing your Coverage under COBRA*, to see how you may extend your coverage.

Except in cases of divorce or a change in a child's status (see sections below regarding each), coverage ends the last day of the month in which you lose eligibility because of one of the events below.

DIVORCE

Former spouses are not eligible for coverage under this program; coverage of a former spouse terminates on the day following the date of the divorce. You must notify your Human Resources/Benefits Office or Office of Pensions, if you are a pensioner, of the divorce and provide them with a copy of your divorce decree. An enrollment form/application must be completed within 30 days of the divorce. You should state "divorce" as the reason for the change.

Coverage ends on the day after the date the divorce is granted. Failure to provide notice of your divorce to your Human Resources/Benefits Office or Office of Pensions, if you are a pensioner, will result in your being held financially responsible for the cost of premium, health care and prescription services provided to your former spouse and his or her children.

LEAVE YOUR JOB

Coverage terminates at the end of the month in which you leave your job.

DEATH

Your coverage ends on the day of your death. Coverage ends for your dependents at the end of the month in which you die, except for dependents of pensioners. Coverage for dependents of pensioners ends either:

- the last day of the month of your death; or
- if contributions have already been made, the last day of the following month; or
- when the dependent no longer meets eligibility conditions.

Dependents of pensioner, upon the pensioner's death, should contact the State's Office of Pensions to discuss options of continued coverage.

CHANGE IN YOUR JOB STATUS

Coverage ends when you're no longer eligible through your job. This might happen if you begin to work fewer hours, etc. Please refer to the section, *You Are Eligible To Be Covered If*, above.

CHANGE IN CHILD'S STATUS

Unless covered as a disabled child, your child's coverage ends at the end of the month in which he or she reaches:

- age 26, if your natural or adoptive child;
- age 19, if eligible under the terms described in Coverage for Other Children;
- age 24, if similarly eligible and a student.

THE PLAN IS CANCELED

Coverage ends the day the State of Delaware's contract with Highmark Delaware ends.

BENEFITS AFTER YOUR COVERAGE ENDS

All benefits end when your coverage ends, except:

- if the State of Delaware cancels its contract with Highmark Delaware; and
- if you are an inpatient on the date the contract ends.

You're covered for the care you receive as an inpatient. The Plan covers you through the earlier of:

- 10 days after the contract ends; or
- until you are discharged

CONTINUING YOUR COVERAGE UNDER COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives you the right to continue your coverage after you lose coverage under this Plan, provided you meet COBRA's definition of a *qualified beneficiary*. If you decide to continue your coverage, you will have to pay up to 102% of the cost of coverage.

The following is a brief explanation of the law:

EMPLOYEE

You (and your dependents) can continue coverage for up to 18 months if you lose group coverage because:

- your hours at work are reduced; or
- your job ends (for reasons other than gross misconduct).

You, the employee, can continue coverage beyond 18 months if you:

- are disabled when you become eligible for COBRA coverage; or
- become disabled within the first 60 days of COBRA coverage; and
- are considered disabled by the Social Security Administration.

You are then entitled to an additional 11 months (totaling 29 months). Your cost would be 150% of the Plan cost for months 19 through 29.

SPOUSE OF EMPLOYEE

Your spouse can continue coverage for up to 36 months if coverage ends because

- you die;
- you divorce your spouse; or
- you become eligible for Medicare.

DEPENDENT CHILD OF EMPLOYEE

A child can continue coverage for up to 36 months if coverage ends because:

- you die;
- you divorce your spouse;
- you become eligible for Medicare; or
- the child is no longer considered a dependent under this Plan.

NOTIFYING YOUR EMPLOYER

You need to notify your Human Resources/Benefits Office, or Office of Pensions if you are a pensioner, within 30 days of a:

- divorce; or
- child losing dependent status; or
- disability determination by the Social Security Administration.

Notify your Human Resources/Benefits Office, or Office of Pensions if you are a pensioner, within 30 days if the Social Security Administration determines you are no longer disabled.

Your Human Resources/Benefits Office, or Office of Pensions if you are a pensioner, will have information about COBRA and how much it costs mailed to you. You can choose to continue coverage under COBRA. If you do, then you have the right to the same coverage as the active employees. If you don't, your coverage under this Plan ends.

You should contact State of Delaware's COBRA Administrator if you have any questions. The phone number is: 800.877.7994.

WHEN YOUR COVERAGE UNDER COBRA ENDS

You can lose the coverage you continued under COBRA if:

- your employer no longer has any group health coverage;
- you don't pay the premium on time;
- you become eligible for Medicare; or
- you get coverage under another group plan. An exception may apply if the other plan:
  - has a preexisting condition waiting period; and
  - provides credit for prior creditable coverage to offset the preexisting condition waiting period.

In such cases, you can be covered under both plans.

You are eligible to receive a standard *Certificate of Coverage* after you lose coverage under COBRA.

DIRECT BILLED PLANS

If your coverage under a group plan with Highmark Delaware ends, you may apply to Highmark Delaware for a direct billed Conversion Plan. You may also apply for a Conversion Plan when COBRA continuation coverage is exhausted.

With a Conversion Plan, Highmark Delaware bills you directly for your coverage.

The Conversion plan may have different benefits from your group plan. It may cover fewer items and pay a lower amount. Conversion plans cover children through the end of the month in which they reach age 26. Children over age 26 can apply for a direct billed plan of their own.

The following information applies to conversion plans:

- You must apply within 30 days after the group plan ends.
- You cannot be eligible for any other group plan. This applies if you're eligible through your or your spouse's (or same-sex domestic partner's), employer or any organization. It applies even if:
  - the other plan has a preexisting condition limit, or
  - the other plan denied your application.
- You cannot be eligible for Medicare.
- There is no medical underwriting.

For more information about Conversion Plans or other direct billed plans, call Highmark Delaware's Customer Service department at the number listed in the front of your booklet. If you do not reside in Delaware, you may contact your local Blue Cross Blue Shield plan for more information.

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A GUIDE TO FILING CLAIMS AND APPEALS

Always be sure to show your Highmark Delaware ID card when you receive care!

HOW TO FILE CLAIMS

In most cases, claims are filed for you by your provider. This is usually true when you use a **participating provider.**

WHEN YOU USE A NETWORK PROVIDER

Highmark Delaware's network providers file claims with Highmark Delaware for you. They also accept our allowable charge as full payment for covered services. You still pay your share (any copayment, deductible or coinsurance). Highmark Delaware pays network providers for your care.

WHEN YOU USE A NON-NETWORK PROVIDER

Non-Network providers fall into two categories: those who have contracts to participate with Highmark Delaware, and those who do not.

Many doctors and other providers contract with Highmark Delaware. They are called "participating providers". These providers agree to accept our allowable charge as full payment. They cannot bill you more than our allowable charge for covered services, even if their normal charge is higher. And, these providers file claims with Highmark Delaware for you. So you don't need to complete claim forms.

Some providers don't have a contract with us. They may ask you to pay the full cost for your care, and they may bill you for amounts over our allowable charge.

If you receive care from a non-participating provider you may need to submit a claim for your care. If we cover the service, we'll pay the allowable charge to you, less any copayment, deductible or coinsurance. This is the same payment we make to participating providers. You must pay any balance over our payment.

WHEN YOU'RE OUT OF AREA

When you receive care in another state, show your Highmark Delaware ID card. Providers participating with the local plan may file your claim with the local plan.

Under the BlueCard® Program:

- you pay any copayment or coinsurance;
- the local plan accepts the provider's claim; and
- payment is made to the provider.

IF YOU NEED TO FILE A CLAIM

To obtain a form, call Customer Service. You may also get the form from the Highmark Delaware website, **highmarkbcbsde.com**.

Please follow the instructions on the form. Attach an itemized receipt from the provider. Send your claim to this address:

Claims
Highmark Blue Cross Blue Shield Delaware
P. O. Box 8831
Wilmington, DE 19899-8831

HOW TO APPEAL A CLAIM DECISION

You have the right to a full and fair review of all claim decisions. Here's how the appeal process works:

HIGHMARK DELAWARE'S APPEAL PROCESS

- To appeal a Highmark Delaware decision, you or your representative must contact Customer Service ***within 180 days*** from the date you received the decision. You may call us or you may use the Highmark Delaware *Appeal Form*, available at **highmarkbcbsde.com/downloads/AppealForm.pdf**. There is no cost to appeal, and Highmark Delaware will provide copies of records relevant to your claim upon written request. Members should use the *Designation of Personal Representative for Appeal Purposes* form (available at **highmarkbcbsde.com/downloads/PersonalRepDesignationAppeal.pdf**) to designate a personal representative for purposes of an appeal.

- Please explain why you believe the decision was wrong and provide any additional relevant information. If you fail to submit your appeal within the 180-day timeframe, your appeal will be rejected and the initial decision will be upheld.

- **Pre-service decision**: For appeals relating to a service you have not received (Highmark Delaware denied authorization and you have not received the service or treatment), you will be notified of the appeal decision within 30 days of your request. You may request an **expedited** appeal for coverage relating to urgent care. We will make an expedited appeal decision and notify you and your provider within 72 hours of your request.

- **Post-service decision**: For appeals relating to a service you have already received, you will be notified of the decision within 30 to 60 days of your request for an appeal.

AFTER THE HIGHMARK DELAWARE APPEAL

- If you have appealed a decision and are not satisfied with the outcome, you may be eligible for an external review coordinated by the Delaware Department of Insurance (DOI). As required by law, you must request an external review within four months of the date you received Highmark Delaware's appeal decision.
  - For decisions involving medical judgment or necessity, you must contact Highmark Delaware Customer Service to initiate the review.
  - For reviews of all other decisions, you must contact the DOI directly at 302.739.4251.

- The DOI provides free, informal mediation services which are in addition to, but do not replace, your right to an independent review. For information about mediation, you can call the DOI Consumer Services Division at **302.739.4251** or **800.282.8611**, or visit the DOI office at: The Rodney Building, 841 Silver Lake Boulevard, Dover, Delaware. Office hours

are 8:30 AM – 4:00 PM Monday – Friday. **Please note that the four month external review deadline will still apply if you choose mediation services.**

ADDITIONAL LEVELS OF APPEALS

For information on additional levels of appeal availability, please see http://ben.omb.delaware.gov/medical/bcbs/ or telephone the State of Delaware's Benefits Office at 800.489.8933 or 302.739.8331.

If you would like more information, please contact Highmark Delaware's Customer Service Appeals Team by one of the methods below.

Internet:

Visit our internet Customer Service Center at **highmarkbcbsde.com**.

Telephone:

800.633.2563
800.232.5460 for the hearing impaired

Mail:

Highmark Blue Cross Blue Shield Delaware
PO Box 8832
Wilmington, DE 19899-8832

COORDINATION OF BENEFITS

Highmark Delaware coordinates payments with any other plan that covers you, your spouse or your dependents. We assure the combined payments don't exceed 100% of the Allowable Expense. This process is described below.

SPOUSAL BENEFITS

We will pay 20% for your spouse's benefits if:

- your spouse's employer has a benefit plan; and
- your spouse is eligible; and
- your spouse didn't join the plan.

See the section, *A Guide to Enrollment Information*, for special rules about enrolling your spouse.

TERMS

These terms are used to explain the rules for Coordination of Benefits (COB):

- *Allowable Expense* is a necessary, reasonable and usual health care expense. The expense must be covered at least in part by a plan that covers you.
- *COB Provision* sets the order in which plans pay when you're covered by two or more plans. Note: A member may not be covered more than once under the State of Delaware's Group Health Insurance Program.
- *Other Plan* is any arrangement you have that covers your health care.
- *Primary Plan* is the plan applied before any other plan. Benefits under this plan are set without considering the other plan's benefits.
- *Secondary Plan* is the plan applied after the other plan. Benefits under this plan may be cut because of the other plan's benefits.

ORDER OF BENEFITS DETERMINATION

The primary and secondary plan payments are set by these rules:

- A plan with no COB rules is primary over a plan with such rules.
- A plan which covers you as an employee is primary over a plan which covers you as a dependent.
- A plan which covers you as an active employee is primary over a plan which covers you as a non-active employee. Non-active means a laid off or retired employee. This rule also applies if you're the employee's dependent.
- For a child covered by plans under both parents, these rules apply:
  - The plan of the parent whose birthday comes first in the year is primary.
  - If both parents have the same birthday, the plan that covered one parent longer is primary.
  - The other plan's COB rules may set the payment order by the parent's gender. In this case, the male parent's plan is primary.
- If the parents are divorced or separated, this order applies:
  - First, the plan of the parent with custody;
  - Then, the plan of the spouse of the parent with custody; and
  - Last, the plan of the parent not having custody.

This order can change by court decree. A court decree may make one parent responsible for the child's health care costs. If so, that parent's plan is primary.

- If these rules don't decide the primary plan, then the plan covering you longest is primary.
- There may be two or more secondary plans. If so, these rules repeat until this plan's obligation for benefits is set.

EFFECT ON BENEFITS

- When this plan is primary, we pay without regard to any secondary plan.
- When this plan is secondary, we account for payments made by other plans. We'll coordinate with the other plans. We'll make sure payments by all plans don't exceed the Allowable Expenses. Our payment will never be more than if we were primary.
- If the other plan is primary and reduces or does not cover benefits because there is coverage under this plan, then we'll calculate the benefit as if:
  - the State's plan is secondary, and
  - the other plan had paid the normal payment.

COB AND MANAGED CARE REQUIREMENTS

The rules below will apply to you, your spouse and your dependent children. Please also refer to the section *Managed Care Requirements*.

COB When This Plan is Primary

The State's managed care requirements must be followed. If they are not followed, benefits are coordinated by applying the penalties of this plan.

COB When This Plan is Secondary

Highmark Delaware will never pay more than what we would pay if this plan were primary.

You don't have to follow the State's managed care requirements when this plan is secondary. However, you should follow the primary plan's managed care requirements.

- If you do, both plans will pay up to the maximum.
- If you don't, we'll apply the other plan's penalties when calculating your benefit payment.

We will coordinate benefits if the primary plan:

- Has a Preferred Provider Network;
- Is a Point of Service Plan.

You will have to follow the primary plan's In-Network or Out-of-Network managed care requirements to get the maximum payment.

Exceptions are:

- This plan may cover care that the other plan doesn't cover. If this happens, we'll pay benefits as if this plan were primary. You must follow the State's managed care rules to receive maximum payment.
- The other plan may have a day or dollar maximum on a particular benefit. This plan will pay benefits if:
  - you've met the maximum for that benefit, and
  - this plan covers the particular benefit.

The State's plan will pay until you are again eligible for that benefit under the other plan.

To file a secondary claim, you'll need to send Highmark Delaware a completed claim form (see *A Guide to Claims*) and a copy of your Explanation of Benefits (EOB) from the other carrier. That way we'll be able to see what the primary plan paid and what the managed care penalties were, if any.

HOW COB WORKS WITH PROVIDER NETWORKS

If you are covered under both a State plan and another plan, we will coordinate benefits.

When This Plan is Primary

If this plan is primary, the State's network and managed care requirements will apply.

When This Plan is Secondary

If the primary (other) plan has managed care requirements or a provider network, you must follow those requirements and utilize the network to get maximum payment for both the primary and secondary (State) programs. If you followed the other plan's managed care requirements, you don't have to follow the State's managed care requirements.

We will apply the other plan's out-of-network payment reductions when applicable.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

We have the right to decide when to apply COB rules. To do this, we may obtain information as needed. We may also release information to any organization or person as needed.

You must give us the information we need to apply COB rules. This includes information about you and your dependents. If you do not cooperate, we may deny payment.

FACILITY OF PAYMENT

If we're primary, but the other plan paid a claim, we have the right to pay the other plan. Our payment will be the amount we decide is our share under COB rules. Such a payment will meet our obligation under this plan.

RIGHT OF RECOVERY

If we paid more than our share under COB rules, we'll recover the excess from:

- you or any person to or for whom such payments were made;
- any insurance plan;
- other organizations.

Please refer to the section, **Subrogation and Right of Reimbursement**, in *General Conditions*, below.

HIGHMARK DELAWARE QUALITY INITIATIVES

Highmark Delaware is committed to offer you quality benefits and services. We have established a clearly defined process to evaluate whether new health care technology and treatments are medically appropriate and supported by sound research.

OUR EVALUATION PROCESS

Our Medical Technology Assessment Committee meets quarterly to evaluate newly proposed technology and treatment benefits. The Committee is made up of

- physicians;
- nurses;
- health care specialty providers; and
- senior-level quality administrators.

The Committee consults comprehensive, nationally recognized research sources. These sources may include reports from the National Institute of Health, the Journal of the American Medical Association, the New England Journal of Medicine and others as needed.

The Committee uses the following evaluation criteria:

- The technology or treatment must have final approval from the appropriate regulatory body (such as the U.S. Food and Drug Administration).
- The scientific evidence must be conclusive.
- The technology or treatment must improve overall health outcomes. The health improvement must be available outside the investigational setting.
- The technology or treatment must be as good as other established treatment alternatives.
- The technology or treatment must be within the scope of local clinical practice and standards.

Through this process we help make sure that you receive quality health care benefits and services.

CURIOUS ABOUT QUALITY?

Highmark Delaware is proud to share with our members how we work to continuously improve upon the services we offer. We invite you to request copies of Highmark Delaware's quality improvement standards and initiatives by sending a written request to:

Highmark Blue Cross Blue Shield Delaware
Attn: Director of Quality Improvement
P.O. Box 1991
Wilmington, DE 19899-1991

GENERAL CONDITIONS

RELEASING NEEDED RECORDS

Your providers have information about you we need to apply benefits. When you applied for coverage, you agreed to let providers give us information we need. This includes the diagnosis and history of your care. This applies to any condition or symptom you had or for which you sought care. It may also include other information. We'll keep these records private as allowed by law.

When you applied for coverage, you authorized us to share records of your health when needed. We'll only share your records to apply your benefits. We may share your records with:

- a medical review board;
- a utilization review board or company;
- any other health benefit plan; or
- any other insurance company

If the records relate to fraud or other illegal act, we may disclose them to legal authorities. We may also use them in legal actions.

We may charge a fee for making copies of claim records.

DUAL ENROLLMENT

You may have two or more benefit plans with us. If so, we'll coordinate benefits. However, you may not be enrolled more than once through the State of Delaware.

TIME LIMITS

You must file a claim within 2 years after you receive care. We won't pay a claim filed past the 2 year limit.

DENIAL OF LIABILITY

We're not responsible for the quality of care you receive from a provider. Your coverage doesn't give you any claim, right or cause of action against us based on care by a provider.

NON-ASSIGNABILITY

Any right you have to care is personal and cannot be assigned. Any right you have to payments is personal. Your payment rights cannot be assigned without our written approval.

FINANCIAL RISK DISCLAIMER

Highmark Delaware provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

SUBROGATION AND RIGHT OF REIMBURSEMENT

When we pay a claim, we are subrogated to all rights of reimbursement you have against any third party. A third party includes, but is not limited to, another person, legal entity (such as a corporation or self-insured plan), or insurer (providing you uninsured or underinsured automobile coverage, other automobile coverage, workers compensation, malpractice, or other liability coverage). We will have the sole right to interpret all rights and duties created by this section.

Some examples of Highmark Delaware's rights include:

- **Constructive trust.** Accepting benefits from Highmark Delaware makes you and your agents a constructive trustee of any funds recovered from any third party. This constructive trust will continue until Highmark Delaware receives payment. Failure to pay funds to Highmark Delaware will be considered a breach of your duty to the health care plan. No settlement can be made without Highmark Delaware's written permission.
- **Subrogation lien.** Accepting benefits from Highmark Delaware will result in an automatic lien by Highmark Delaware against any recovery from any third party. This means Highmark Delaware has the right to first dollar recovery of those funds, whether or not those funds make you whole. First dollar means that Highmark Delaware has first priority to recover from any and all payments made by the third party. Recovery means any judgment, settlement or other obligation to pay money. Highmark Delaware is entitled to recovery from any party possessing the funds.
- **Recovery from a third party.** Highmark Delaware is entitled to be paid from any recovery, no matter how the recovery is categorized. Some examples include recovery for lost wages only or pain and suffering only. You will be responsible for any attorney's fee and costs of litigation.

Some examples of your responsibilities include:

- **Notifying Highmark Delaware.** If you are involved in an accident or incident that results in both Highmark Delaware paying a claim and you having a claim against any third party, you must notify Highmark Delaware in writing within 30 days.
- **Cooperating with Highmark Delaware.** You are required to cooperate with Highmark Delaware and assist in the recovery from the third party.

LEGAL ACTION

There's a 2 year time limit past which you cannot bring legal action against us for not paying a claim. The period begins on the date of service.

POLICIES AND PROCEDURES

To make sure this plan functions as it should, we may adopt any reasonable:

- policies;
- procedures;
- rules; and
- interpretations.

You agree to abide by these rules. If you don't, we may cancel your coverage.

MISREPRESENTATION, FRAUD OR OTHER INTENTIONAL ACT

We may cancel your coverage if we learn:

- Statements you made when you applied or afterward were untrue or not complete.
- You received or tried to receive benefits under this plan through misrepresentation, fraud or other intentional misconduct.
- You helped someone else in either of the acts noted above.

OUT-OF-AREA SERVICES

Highmark Delaware has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of our service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between us and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside our service area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-participating healthcare providers. Highmark Delaware's payment practices in both instances are described below.

BLUECARD PROGRAM

Under the BlueCard Program, when you access covered healthcare services within the geographic area served by a Host Blue, Highmark Delaware will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever you access covered healthcare services outside our service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

NON-PARTICIPATING HEALTHCARE PROVIDERS OUTSIDE HIGHMARK DELAWARE'S SERVICE AREA

Your (Member) Liability Calculation

When Out-of-Area Covered Healthcare Services are received from non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's non-participating healthcare provider local payment or the pricing arrangements required by

applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the covered services as set forth in the State of Delaware contract.

DEFINITIONS

Admission: The time you're an inpatient in a

- hospital
- skilled nursing home
- other facility

The admission runs from the day you're admitted until discharge.

Allowable Charge: The price Highmark Delaware determines is reasonable for care or supplies. See "Allowable Charge Calculations Under the BlueCard Program" in *General Conditions* for more information.

Ambulatory Surgical Centers: Approved outpatient facilities for surgeries.

Birthing Center: Maternity centers that monitor normal pregnancies and perform deliveries.

Blue Distinction Centers for Bariatric Surgery (BDCBS) refers to facilities recognized by the Blue Cross Blue Shield Association to have demonstrated its commitment to quality care, resulting in better overall outcomes for bariatric patients. Each facility meets stringent clinical criteria, developed in collaboration with expert physicians and medical organizations*, including the American Society for Metabolic and Bariatric Surgery (ASMBS), the Surgical Review Corporation (SRC) and the American College of Surgeons (ACS), and is subject to periodic reevaluation as criteria continue to evolve. A list of these facilities may be found at **bcbs.com**.

Blue Distinction Centers for Transplants (BDCT): BDCTs are facilities which participate in a Blue Cross Blue Shield Association transplant program and have demonstrated commitments to quality care, resulting in better overall outcomes for organ transplant patients. A list of these facilities and their transplant programs may be found at **bcbs.com**

Coinsurance: The percent of allowable charges you pay.

Coinsurance Expense Limit: The total amount of coinsurance you pay. When you reach the Limit, our payments increase to 100% of allowable charges. The Limit does not include:

- copayments, if any
- amounts over the allowable charge
- charges for non-covered care

Consultation: An interview or exam by a doctor other than the doctor treating you. The doctor is usually a specialist.

Deductible: The amount you pay before benefits are applied.

Doctor or Physician: A licensed physician, osteopath, podiatrist or dentist. Such a provider must be acting within the scope of his or her license. (Coverage for dental care is limited. See *Surgical and Medical Benefits* and *What Is Not Covered* sections, above.)

Facility: A hospital, skilled nursing home, outpatient care site or like institution.

Highmark Delaware: Highmark Blue Cross Blue Shield Delaware.

Hospital:

- *Acute Hospital:* An institution or division of an institution. On an inpatient basis, it primarily provides diagnostic and therapeutic facilities for:
  - surgical and medical diagnosis and treatment
  - care of obstetric cases

Acute hospitals must be approved by:
- the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or
- the American Osteopathic Association (AOA)

Such hospitals charge for their care and receive payments from patients. Facilities and care are supervised or rendered by a staff of licensed doctors. Such hospitals provide 24 hour a day nursing care. The nursing care is under the supervision of registered graduate nurses.

- *Non-Acute Hospital:* An institution that provides care distinct from care usually received in an Acute Hospital. It may be a division, section or part of an Acute Hospital. Non-Acute Hospitals must be approved by:
  - Highmark Delaware
  - the appropriate state or local agency (if required by law)

  Such hospitals charge for their care and receive payments from patients.
- The term **Hospital** does not include the following:
  - nursing homes
  - rest homes
  - health resorts
  - homes for aged
  - infirmaries or places solely for domiciliary care, custodial care, care of drug addiction or alcoholism
  - similar facilities that provide mostly nonmedical services

HRA: Health Reimbursement Arrangement, a spending account to help pay for out-of-pocket expenses.

Imaging: A diagnostic process that shows soft tissue and bones. This includes X-rays, mammograms and magnetic resonance imaging (MRI).

Inpatient: A person in a hospital, skilled nursing home or other facility for an overnight stay.

Machine Test: A test using a device to diagnose a condition. This includes EKGs and EEGs.

Medically Necessary: Care, required to identify or treat a condition, which:
- is consistent with the symptoms or treatment of the condition
- meets the standards of accepted practice
- is not solely for anyone's convenience, and
- is the most appropriate supply or level of care which can be safely provided. For inpatient care, it means the care cannot be safely provided as an outpatient.

Network Provider: A provider with a contract to be a member of Highmark Delaware's preferred network.

Outpatient: A person receiving care while not an inpatient.

Participating Provider: A provider with a Highmark Delaware participating contract. Participating providers will not bill you over the allowable charge for a covered service.

Prescription Drugs: Drugs which are:
- obtained only through a doctor's prescription
- listed in the U.S. Pharmacopoeia or National Formulary, and
- approved by the Food & Drug Administration

Provider: The organization or person giving care, supplies or drugs.

Reopening Period/Open Enrollment Period: The time when you may make changes to your coverage.

Semiprivate Room: A room with at least two beds.

Specialist: A doctor to whom you are referred for care. Sometimes called a *Referral Doctor*.

Specialized Care Facility: A facility for drug and alcohol treatment.

Spouse: A person to whom you are married or partnered in a civil union, pursuant to the laws of the State of Delaware.

We, Us or Our: Refers to Highmark Blue Cross Blue Shield Delaware.

You and Your: Refers to the employee or any of the employee's eligible dependents enrolled in this plan.

IMPORTANT PHONE NUMBERS AND ADDRESSES

Customer Service:

(For questions about benefits, claims and membership)

Customer Service
Highmark Blue Cross Blue Shield Delaware
P. O. Box 1991
Wilmington, DE 19899-1991

All Calls: 800.633.2563

Medical Management and Policy Department:

(For Managed Care)

Medical Management and Policy Department
Highmark Blue Cross Blue Shield Delaware
P. O. Box 1991
Wilmington, DE 19899-1991

All Calls: 800.572.2872

Behavioral Health Care Department:

(For Mental Health and Substance Abuse Managed Care Program)

Behavioral Health Care Department
Highmark Blue Cross Blue Shield Delaware
P.O. Box 1991
Wilmington, DE 19899-1991

All Calls: 800.421.4577

Claims:

(For sending in your health care claims)

Claims
Highmark Blue Cross Blue Shield Delaware
P.O. Box 8831
Wilmington, DE 19899-8831

Your Doctor(s):

(Write down your doctors' Names and Phone Numbers for all family members)

Member's Name	Doctor's Name	Phone Number

State of Delaware CDH GOLD HRA PPO

Print Date: 04/29/14

Completed: 05/07/14